

Structure and Change in the Formation of Fall Risk Management Ability in Newly Recruited Nurses

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Structure and Change in the Formation of Fall Risk Management Ability in Newly Recruited Nurses

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Abstract

The purpose of this study is to clarify the structure and change of fall prevention risk management ability formation in nurses through an examination of nurses at 2 time points, 6 months and 12 months post hiring. Participants were 28 nurses hired at a general hospital in April, 2004 immediately after completion of their basic nursing education. The semi-structured interview method was used for data collection once at each point for participants. The ethnographic analysis method by Spradley was also used to analyze all data of each point. Furthermore, we compared two time points from the category content drawn from 6- and 12-month data. In addition, we also compared the category content and the characteristics of 4 factors of the experiential learning model by Kolb, and examined the characteristics.

This investigation revealed that the self-evaluation of ability that nurses carried out reflected **the reasons why I feel still insufficiently trained** through fall prevention activity by **the methods for fall prevention using incidental information** and experience to reflect **the reasons why I cannot get away with letting patients fall** at 6 months. And, from this, the nurses have begun to assimilate **fall prevention** and, thereby, developed ability by carrying out **the methods for fall prevention using incidental information**.

At 12 months, the nurses began to lead **fall prevention by expanding ADL** from experience and self-evaluated ability that reflected **the reasons why I feel responsible for patient falls** and **the reasons why I recognize the difficulty in completely preventing falls**.

Changes were noted between the two time points in regard to recognition of and the reasons for the seriousness of falling, self-evaluated ability, attitude required for fall prevention, fall prediction and the actions taken for fall prevention. New nurses clarified the attitude required for fall prevention through concrete experience that provided recognition of the seriousness of falls and reflecting on their actions, and took actions for fall prevention in line with this. In other words, recognition of the seriousness of falling, self-evaluated ability, attitude required for fall prevention and fall prediction and actions taken for fall prevention followed the cycle of the experiential learning model that allowed nurses to structure the formation of fall risk management ability according to these categories at the two time points. Therefore it was suggested that new nurses need involvement to promote the development of their experiential learning.

Key words

risk management, formation of ability, newly recruited nurse, experiential learning, fall

Introduction

Risk management at medical facilities is currently an important issue in nursing

management where the medical environment has changed greatly. Approximately 13% of the incidents occurring at medical facilities are

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reported to involve patients under the care of nurses whose vocational experience is one year or less^{1,2)}. Furthermore, falling accounted for the highest rate³⁾ of incidents related to care during medical treatment, and the rate of elderly in-patient falls (include tumbles) was reported to be 10 - 20%⁴⁾. This suggests that many of the in-patients experiencing falls are those under the care of new nurses (hereafter, nurses). In light of this finding, a clarification of the process of fall risk management ability formation in nurses is required in order to improve the judgment and practical ability of nurses in adopting fall prevention measures⁵⁾.

Benner⁶⁾ clarified the characteristics of practice of each nursing development level from novice to expert in terms of the Dreyfus Model. This is premised on the notion that skill level changes through experience and increased proficiency, showing, therefore, the necessity of developing clinical knowledge continuously through experiential learning. When the nurses with at least three years clinical experience developed fall prevention plans, they used knowledge and skill that they had cultivated from their experience⁷⁾. Therefore, it is my belief that nurses begin developing their fall risk management ability from the moment they begin working through participation in fall prevention activities and by witnessing in-patient falls on wards they are assigned to.

There is some research related to work adjustment^{8,9)}, evaluation and development of clinical ability^{10,11)} and first-year experience after becoming employed¹²⁾ among previously published research on nurses. There also exists some research reporting conditions surrounding the occurrence of incidents and accidents¹³⁾ among research related to risk management. However, there are no reports focusing on the formation of fall risk management ability in newly recruited nurses through clinical experience.

The purpose of this study is to clarify the structure and change of fall prevention risk management ability formation in nurses through an examination of nurses at 2 time points, 6 months and 12 months post hiring.

Method

The research design was qualitative and descriptive research based on factor exploration by semi-structured interview method, and we used the ethnographic analysis method by Spradley¹⁴⁾.

The ethnography which we used in this study is methodology describing culture that is 'the acquired knowledge that people use to interpret experience and generate social behavior'¹⁵⁾.

The ward that the nurses were assigned to already had a concept of fall risk management and ethics. At such a medical site, nurses believed that they were establishing an original concept of fall risk management and behavior while accumulating clinical experience. Therefore, we believed that we could understand the formation of the thought and behavior of nurses tied to culture for the fall risk management on wards to which they were assigned had in place.

Spradley¹⁶⁾ states that in the research of cultures different from the investigator's it is necessary to deal with the experience of individuals from three different aspects: what they are doing; what they know; and what they create. He states that experience consists of facts and those facts are expressed through the language used by the individuals¹⁷⁾. Therefore, we decided to clarify fall risk management ability formation in nurses by collecting the words of expression for what nurses are doing for in-patient fall prevention, what they know and what they create and use from their experiences as data, and analyzing the meaning of the collected data.

The process of ability formation is equivalent to the process of experiential learning¹⁸⁾. Therefore, we employed the widely used experiential learning model by Kolb¹⁹⁾ to understand the ability formation of fall risk management in professionals^{20,22)} as an index for data collection and analysis. Kolb defined learning as "a process whereby knowledge is created through the transformation of experience," and divided the experiential learning model into four stages: concrete experience, reflective observation, abstract conceptualization, and active experimentation.

Table 1 Participant's data

n = 28

Gender	Male: 0 Female: 28
Educational background	Nursing university-educated: 11 Nursing technical school-educated: 17
Ward they belong to	Surgery (Combined): 16 Internal medicine: 6 Orthopedics: 3 Psychiatry: 1 Other: 2
Experience of incidence of the falling (in one year after finding employment)	Experienced the incidence of falling while working: 27 (96.4%) Came across falls: 25 (89.3%)

1) Participants (Table 1)

Participants were 28 nurses hired at one general hospital in April, 2004 immediately after completion of their basic nursing education.

We contacted the head nurse of the hospital which employed more than 50 nurses in April, 2004 in an attempt to gather subjects, explained the purpose of the study and obtained cooperation for the research. Thereafter, we asked all the nurses (56) to participate in the study. We obtained informed consent for participation in this study from 28.

The reason the general hospital was selected as a study site was ease of subject recruitment due to the number of new nurses hired each year at the hospital. In addition, this hospital was selected because fall prevention had become a nursing management issue along with the increasing age of inpatients.

2) Data collection

We used the semi-structured interview method. We carried out the interviews at 6 months (September 2004) and 12 months (March 2005) post hiring. The reason why we focused on the first year post hiring is because a greater number of first-year nurses associated with patient fall incidents occurring at medical facilities. We set the two time points of the interview by reference to the conventional research^{11,23)} that states improvement of ability for judgment and ability for nursing intervention was present between six and ten months post hiring.

Every participant was interviewed once on each occasion. The average time per interview was 53 minutes. The content of the interview included experiences related to falls, perspectives of those experiences, what the interviewee had learned

from the experiences, and what they were doing for fall prevention. In addition, the interviews were scheduled at a time selected by individual participants and took place at a quiet location where individual privacy was protected. The interviews were recorded after obtaining the participants' consent. Hereafter 6 months post hiring is referred to as 6 months, and 12 months post hiring is referred to as 12 months.

3) Analytical method

We started analyzing the 6-month interview data. First, we extracted phrases related to the purpose of the study as the smallest understandable units from a word-for-word transcription created from the interviews. Then we categorized phrases containing common meanings. We examined the relationships within each category for similarity and difference, and integrated the categories. Relationships among components of a category were clarified using the 9 types of semantic relationships²⁴⁾ defined by Spradley. In addition, categories were composed of cover and included terms and expressed in the words used by participants²⁵⁾. When category hierarchization had proceeded and highly abstract categories were formed to an extent, analysis of data collected at 12 months was carried out in the same manner as the analysis of data collected at 6 months. When the categories with a high degree of abstraction in the 12-month analysis was formed, we started searching for pair categories in order to examine the difference between the two time points. Focusing on the pair categories, we proceeded with category hierarchization. When more than 5 layers of subcategories were formed and the relationships between categories solidified, we judged that analysis had reached saturation.

Next, we compared two time points from the category content drawn from 6- and 12-month data. In addition, we also compared the category content and the characteristics of 4 factors of the experiential learning model, and examined the characteristics. The extracted categories show how nurses developed fall risk management ability. Therefore, we considered that a comparison of the categories that were expressed by the words of the nurses with 4 elements of the experiential learning model to be appropriate to an understanding of the formation of fall risk management ability in nurses.

To ensure the credibility of this qualitative study²⁵⁾, university faculty members who had research experience of fall risk management and researcher who had qualitative research experience were asked to examine the results of the analysis. Results were also shown to participants and persons who were in charge of nursing education at hospitals, and the validity of contents was confirmed.

4) Ethical considerations

We explained the purpose and methods of this study to the head nurse at the general hospital and asked for her cooperation for the research. We also explained the purpose of the study, study methods, anonymity and data management to nurses both verbally and in writing, and obtained their written consent. We again explained the purpose and methods of the study to the participants before the start interviews and confirmed agreement to participate in the study. We started interviews with questions concerning actions related to fall prevention that the nurses took on a daily basis that the participant would find easy to answer. Investigators listened without evaluating the comments of the participants.

Results

1. Constituents of fall risk management ability formation (Fig.1)

The formation of fall risk management ability was divided into four categories both at 6 months and 12 months. Formation at 6 months consists of **the reasons why I feel I cannot get away with letting patients fall, the reasons why I feel still**

insufficiently trained, fall prevention and the methods for fall prevention using incidental information. Formation at 12 months consisted of **the reasons why I feel responsible for patient falls, the reasons why I recognize the difficulty in completely preventing falls, fall prevention by expanding ADL and the methods for fall prevention anticipating patient activities.**

Titles of categories, subcategories and participant statements are written in gothic typeface, italic typeface and with quotation marks, respectively.

As shown in Fig.1, categories of 6 months and 12 months revealed four pairs from the properties of the categories. The common characteristic of the two categories, **the reasons why I feel I cannot get away with letting patients fall and the reasons why I feel responsible for patient falls** was a recognition of the seriousness of falling. Likewise, **the reasons why I feel still insufficiently trained and the reasons why I recognize the difficulty in completely preventing falls** was self-evaluated ability. **Fall prevention and fall prevention by expanding ADL** was thinking required for fall prevention. **The methods for fall prevention using incidental information and the methods for fall prevention anticipating patient activities** were fall prediction and action taken for fall prevention.

Contents and change of categories by each pair are explained as follows:

1) **The reasons why I feel I cannot get away with letting patients fall and the reasons why I feel responsible for patient falls**

At 6 months, recognition of the seriousness of falling was in the expression, "I cannot get away with letting patients fall". The reasons for this feeling lie in the facts of the *consequences such falls cause in patients' lives and nurses will be scolded by older nurses and doctors*. In other words, the fact of the influence of patient falls on both nurses and patients became the reason for this.

At 12 months, recognition of the seriousness of falling was expressed by, "I feel responsible for patient falls". The reason for this was because *falling causes a delay in patient recovery* and

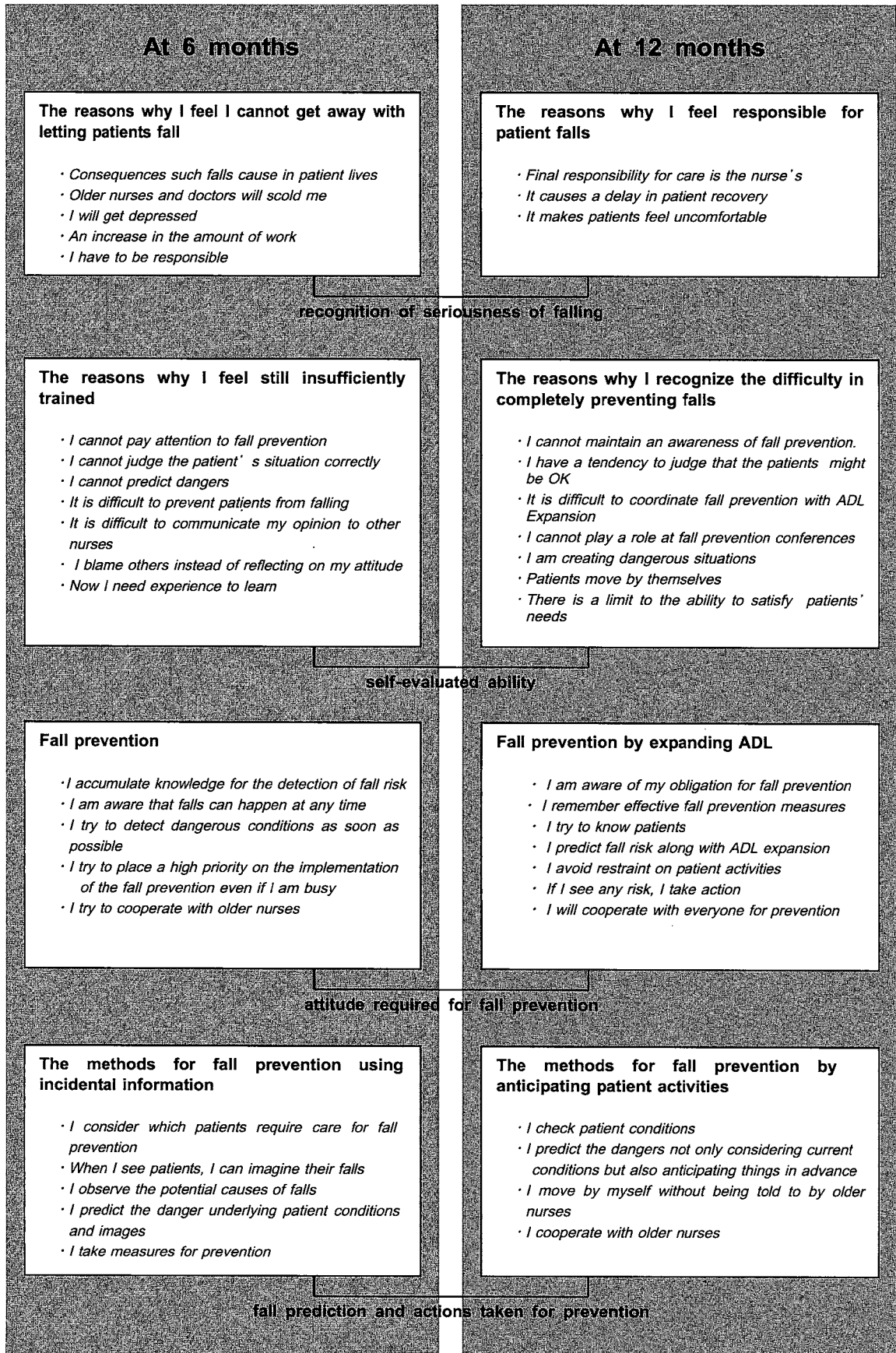


Fig.1 Constituent of fall risk management ability formation
 Gothic Bold Typeface: Categories Italic Typeface: Subcategories
 ┌───┐: meaning the commonality with the categories making a pair

inconvenience for patients, which were the influence on patients caused by the falling. In addition, there was another reason which was that *the final responsibility for care was theirs*. This was recognized by nurses because of their obligation as nurses to ensure the safety of patients.

From the 6-to the 12-month stage, the recognition of the seriousness of falling changed from "I cannot get away with letting patients fall" to "I feel responsible for the patients fall". In addition, respondents felt that "I cannot get away with letting patients fall" because of the negative influence that the fall would bring them, which was *Older nurses and doctors will scold me*, and *an increase in the amount of work*; however, this changed to a feeling that as nurses they were responsible.

2) The reasons why I feel still insufficiently trained and the reasons why I recognize the difficulty in completely preventing falls

At 6 months, nurses expressed their fall risk management ability with the words, "I am still insufficiently trained". The reasons for this judgment were *I cannot pay attention to fall prevention* and *I cannot judge the patient's situation correctly*. These showed the lack of ability expressed by the words "cannot". At 12 months, the words "It is difficult to completely prevent falls" expressed a limitation of ability. The reasons for this judgment were *I cannot maintain an awareness of fall prevention* and *I have a tendency to judge that the patients might be OK. Patients move by themselves and there is a limit to the ability to satisfy patients' needs* were also reasons given. These showed the aspect of patient activities that nursing ability could not handle adequately, a shortage of nursing personnel and the current condition of a nursing system where care for patients with serious diseases is a priority.

At 6 months, reasons given by nurses for feeling "I am still insufficiently trained" were recognized by nurses' looking back on past experience. However, at 12 months, in addition to these past experiences, the current condition of patients and the nursing system that are beyond the control of

nurses were given as reasons.

3) Fall prevention and fall prevention by expanding ADL

At 6 months, this was a lesson learned by recognizing that they were still insufficiently trained. For example, although nurses feel *I cannot pay attention to fall prevention*, they believed that they could pay attention to patients and fall prevention by *being aware that falls could happen at any time*. In addition, although they *cannot predict dangers*, they believed that this lack of ability could be solved by *accumulating knowledge for the detection of fall risk* and by *detecting dangerous conditions as soon as possible*. This was expressed in the words, "detect dangerous condition as soon as possible" and "to place a high priority", indicating that nurses believed it to be important to respond to fall risk by judging it quickly in order to prevent patient falls.

At 12 months, "with ADL expansion" was added as an aspect of fall prevention. In addition, newly recruited nurses believed that it was necessary that nurses *be aware of their obligation for fall prevention*. This belief was informed by a feeling responsibility for patient falls. At 12 months, it was shown that nurses had become strongly aware of their responsibility for fall prevention. Nurses recognized that *knowing patients* is to grasp the physical function and characteristics of patient activities and is necessary for fall prevention along with an increase in patient ability and quality of life. It was also shown that nurses recognized that to *remember effective fall prevention measures* meant to accumulate care methods during their one year of clinical experience, that were effective for fall prevention, and that it was important to utilize these experiences in future practice.

At 6 months, although the focus was on quickly ascertaining and responding to the fall risk, at 12 months, fall prevention measures were introduced with a view toward the process of patient recovery.

4) The methods for fall prevention using incidental information and the methods for fall prevention anticipating patient activities

Action directed at fall prevention at 6 months

was characterized by **the methods for fall prevention using incidental information**. Nurses predicted fall risk utilizing knowledge accumulated as images based on visual information and took preventive action. Preventive measure that was taken was eliminating the causes of falls that existed during patient care. Concentrating on *detecting dangerous conditions as soon as possible*, nurses *considered which patients required care for fall prevention and observed the causes of falling*. Their *observation of potential causes of falls and prediction of the danger underlying patient conditions and images* was indicative of their fall risk management at this stage. At 12 months, nurses reported that they were taking **the methods for fall prevention by anticipating patient activities**. This showed that nurses predicted falls by anticipating patient activities in advance utilizing the information obtained while they were involved with patients.

At 6 months, nurses made fall predictions based on information obtained while they were taking care of patients; however, at 12 months, this changed to becoming an ability to predict falls by anticipating patient activities.

2. Characteristics of categories from the viewpoint of experiential learning models (Fig. 2)

Subcategories of **the reasons why I cannot get away with letting patients fall** at 6 months were caused by incidences of falling that were experienced by the nurses themselves. Therefore, this category possessed the characteristics of concrete experience. **The reasons why I feel still insufficiently trained** were provided by the self-evaluations that nurses made by looking back on what they had done. Therefore, this category had the characteristic of reflective observation. **Fall prevention** was a lesson learned by looking back on one's own actions for fall prevention and expressed abstract conceptualization. In addition, **the methods for fall prevention using incidental information** had the characteristics of both active experimentation and concrete experience. For example, nurses were considering which patients required care for fall prevention in order to detect

any dangerous conditions. In fact, this is active experimentation utilizing **fall prevention** clarified through abstract conceptualization. That *when I see the patients, I can imagine their falls* is not because they were using learned **fall prevention** but rather because their actions at this stage were natural, which is concrete experience. Category characteristics at 6 months are shown in Fig.2.

At 12 months, *it causes a delay in patient recovery and it makes patients feel uncomfortable*, **the reasons why I feel responsible for patient falls** were experienced by nurses as patient responses to falls and as concrete experiences. However, the belief that *final responsibility for care is nurse's* was recognized when nurses looked back on their experience and saw mistakes in judgment and oversights, which is reflective observation. Therefore, **the reasons why I feel responsible for patient falls** exhibit the characteristics of both concrete experience and reflective observation. In regard to **the reasons why I recognize the difficulty in completely preventing falls**, *there is a limit to the ability to satisfy patients' needs and patients move by themselves* are facts that are concrete experiences. Other subcategories were extracted by nurses' looking back on their own actions for fall prevention; therefore, they are reflective observations. **Fall prevention by expanding ADL** was lead by abstract conceptualization. Because **the methods for fall prevention anticipating patient activities** are to apply the fall prevention with expansion of ADL, it is an active experimentation. As mentioned above, category characteristics at 12 months are shown in Fig.2.

3. Structure in the formation of fall risk management ability

At 6 months, the nurses carried out a self-evaluation of their ability that reflected **the reasons why I feel still insufficiently trained** through fall-prevention activities by **the methods for fall prevention using incidental information** and experience reflected in **the reasons why I cannot get away with letting patients fall**. From this, the nurses began to assimilate **fall prevention** and, thereby, developed ability by carrying out **the methods for fall prevention using incidental**

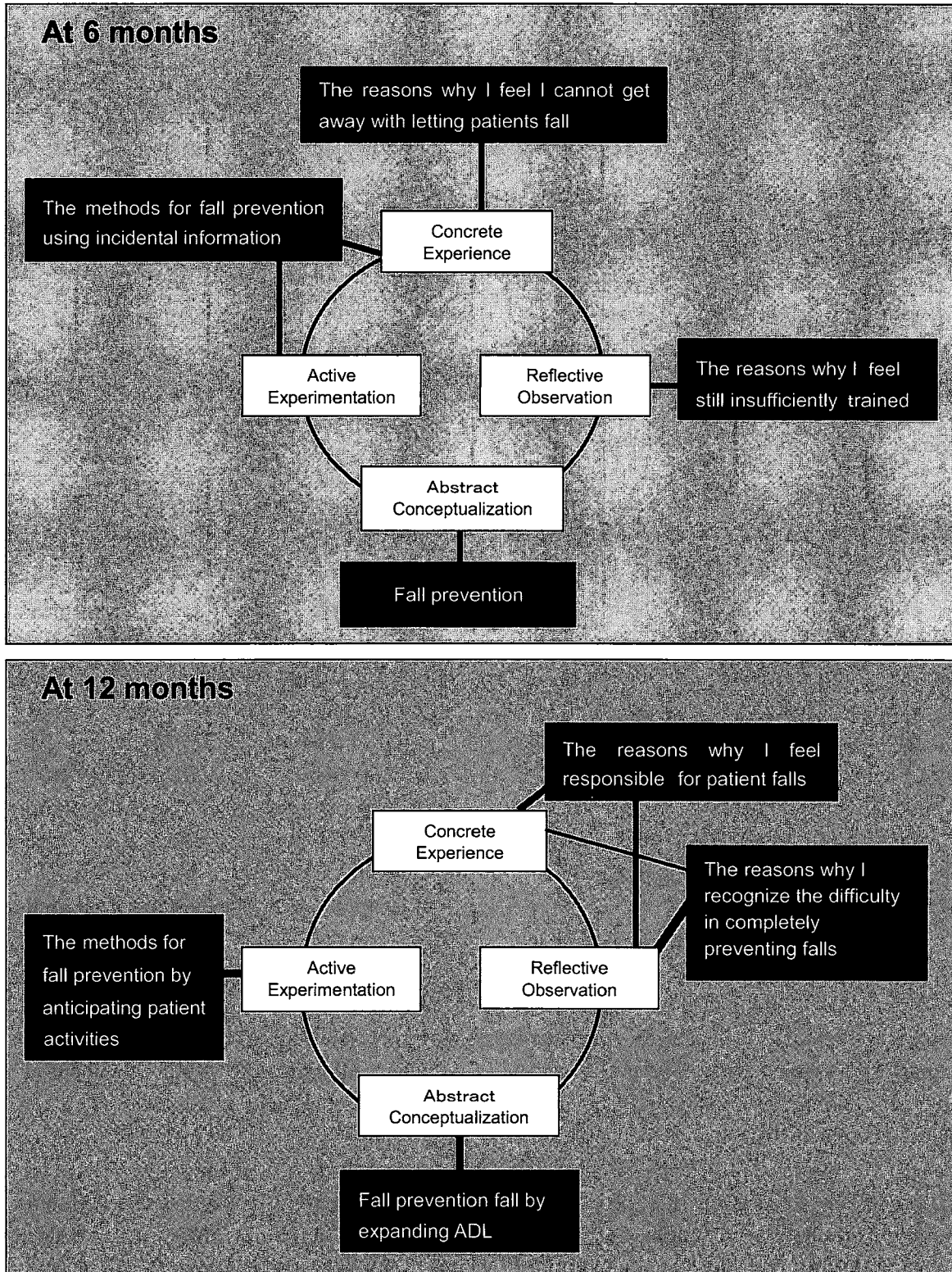


Fig. 2 Characteristics of categories from the viewpoint of experiential learning models²⁹⁾
 ■ Categories ○ Cycle and four stage of experiential learning model
 — express a characteristic of the categories

information.

At 12 months, the nurses began to lead **fall prevention by expanding ADL** from experience and self-evaluated ability that reflected the

reasons why I feel responsible for patient falls and the **reasons why I recognize the difficulty in completely preventing falls**.

In other words, recognition of the seriousness of

falling, self-evaluated ability, attitude required for fall prevention and fall prediction and actions taken for fall prevention followed the cycle of the experiential learning model that allowed nurses to structure the formation of fall risk management ability according to these categories at the two time points.

Discussion

1. Fall risk management ability change in nurses

The methods for fall prevention using incidental information and the methods for fall prevention anticipating patient activities expressed a state of fall risk management ability that nurses were aware of at the two time points.

Results from analysis of 6- and 12-month data revealed three characteristics in the change of nurses' fall risk management ability. The first is fall prediction and implementation of prevention. At 6 months, nurses made predictions based on information obtained while they were taking care of patients, and focused on quick response. At 12 months, however, nurses became able to predict falls not only using information obtained visually, but also by anticipating patients' activities through patient behavior and physical condition. Nurses were preventing falls by maintaining and expanding patient ADL. This change is consistent with research showing that ability in detection and prediction improved 10 months after beginning employment²²⁾. It is believed that knowledge accumulated from the experience of witnessing falls and taking care of patients at high risk for falls helped nurses to anticipate patient activities and improve the ability to predict the danger of falling.

The second is that nurses became aware that the purpose of fall risk management was not to exercise care in avoiding letting patients fall but to work on fall prevention by maintaining and expanding the physical conditions and ADL levels of patients. This was based on their experience that fall prevention by limiting activities created more dangerous activities of patients and lowered their physical abilities and mental activities. Third is that nurses realized that the incidence of falls was a serious matter that they should be assume

responsibility for. This is believed to be realized through the recognition of the seriousness of falling. This change is also believed to be an indication of socialization through the recognition of their obligation as nurses.

2. Characteristics of the formation of fall risk management ability in nurses

In Kolb's experiential learning model, it is stated that individuals follow the process of concrete experience, reflective observation, abstract conceptualization and active experimentation, and create new knowledge, technique and ideas from the experience. New nurses also followed almost the same process and developed their fall risk management ability through accumulated clinical experience. The fact of patient falls was not a concrete experience for new nurses. Recognition that the seriousness of various consequences caused by falls was a concrete experience for new nurses. Honda²⁷⁾ observed that reflection in nursing practice is the search for experience and the attempt to respond when encountering such surprising experiences. Patient falls and the consequences of such falls at the hospitals are surprising experience for nurses. It is believed that nurses formed fall risk management ability by looking back on such experiences.

Nurses drew out fall prevention by looking back on their own actions for fall prevention. This is also the belief that new nurses adopted for fall prevention. Belief is said to direct individual behavior, judgment and evaluation²⁸⁾. It is important for new nurses to adopt a policy to work in the new environment, medical facilities, and assure patient safety.

Four elements of experiential learning were believed to play important roles in forming fall risk management ability in nurses. It is necessary to treat nurses with considering this experiential process to promote their fall risk management ability formation.

3. Limitations of the study and future tasks

Due to the methodological character of this study, the researcher becomes the tool of the study. Therefore, the ability of the researcher to collect and analyze data influenced the results of this

study. In this study, because the nurses of one general hospital were targeted, there is a limit to the untouched application of this study result to the group of nurses. In the future, we would like to clarify the process by which data is collected by using two or more methods to improve the validity of qualitative research, and to investigate how ability in new nurses is promoted by acquisition of more clinical experience by longitudinal study.

Conclusions

1. This investigation revealed that the formation of fall risk management ability in new at 6 nurses months consisted of **the reasons why I feel I cannot get away with letting patients fall, the reasons why I feel still insufficiently trained, fall prevention and the methods for fall prevention using incidental information.**

2. Formation at 12 months consisted of **the reasons why I feel responsible for patient falls, the reasons why I recognize the difficulty in completely preventing falls, fall prevention by expanding ADL and the methods for fall prevention anticipating patient activities.**

3. Changes were noted between the two time points in regard to recognition of the seriousness of falling, self-evaluated ability, attitude required for fall prevention, fall prediction and the actions taken for fall prevention.

4. Nurses formed their fall risk management ability by following a process which was approximately similar to the experience learning model.

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新人看護師の転倒リスクマネジメント能力形成の構造とその変化

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要 旨

本研究の目的は、新人看護師の転倒防止に対するリスクマネジメント能力形成の構造と変化を明らかにすることであり、就職後6ヵ月と12ヵ月の2時点から検討した。対象者は2004年4月に一総合病院に就職した新卒看護師28名である。データ収集は半構成的面接法により、2時点毎に対象者に1回ずつ実施した。分析はSpradleyのエスノグラフィ的分析手法を用い、2時点毎に分析を行った。さらに、6ヵ月と12ヵ月のデータから導き出されたカテゴリの内容から、2つの時期を比較した。つぎに、カテゴリの内容とKolbの経験学習モデルの4要素と対比させながら、その特徴を検討した。

その結果、6ヵ月目では、看護師は飛び込んできた情報から転倒を防ぐ方法による防止活動と転んだらただでは済まないと感じる根拠が示す経験を通して、自分はまだまだであると自覚する根拠が示す能力の自己評価をしていた。そして、このことから、看護師は転倒させないための機能を導き出し、これらを活用しながら飛び込んできた情報から転倒を防ぐ方法を実行することにより能力を形成していた。

12ヵ月目では、転んだら責任が問われると感じる根拠と転倒を100%防ぐのは難しいと認識する根拠が示す経験と能力の自己評価から、ADLを拡大しながら転倒を防止するための機能を導きだしていた。そして、これを活用して患者の行動を想定しながら転倒を防ぐ方法を実行することにより能力を形成していた。

2時点での変化は、転倒発生の重大性の認識、能力の自己評価、転倒防止に求められる態度、転倒予測の方法、防止行動に変化が見られた。新人看護師は、重大性の認識の根拠となった具体的経験、自己を省察することから転倒防止に求められている態度を明確にし、それを活かしながら転倒防止行動をとっていた。つまり、看護師の転倒リスクマネジメント能力の形成は、転倒発生の重大性の認識、能力の自己評価、転倒防止に求められる態度、転倒予測の方法と防止行動の4要素が経験学習モデルのサイクルをたどり、2時点で導き出されたそれぞれ4つのカテゴリから構造化することができた。したがって、新人看護師には、経験に基づく学習の進展を促すような関わりの必要性が示唆された。