Notes on Continuing Education

In response to expressed needs of readers, faculty of the Department of Nursing in University of Wisconsin-Extension have been invited to discuss various aspects of continuing education in this new bimonthly feature. Your suggestions for topics are welcome.

WHAT IS AN ORIENTATION?

According to Morris, to orient is "to cause to become familiar with or adjust to facts, principles, or a situation." The experience of orientation is overwhelmingly familiar to any student or practitioner in nursing. It is an experience repeated many times as students and practitioners rotate from one specialty area or institution to another. The thrust of this paper is to relate the process of orientation to the concepts of need, mastery, and control.

The process of orientation is probably the most tedious aspect of teaching in nursing or supervision in practice. It is an experience usually tedious for the recipient as well. Traditionally the orientation protocol consists of transmission of endless minutiae and procedural detail, given with the expectation that this information is mentally filed by the recipient ready to be recalled at a moment's notice when needed.

As a general rule, orientations are organized into concentrated time frames that are heavily programmed with a variety of disparate content areas. It is not unusual that orientation subject matter is offered by a number of sequential presenters, each focusing heavily on the detail of nonrelated pieces of information. It is usually not possible for an orientee to establish meaningful cognitive linkages with information of this type. In addition, the typical orientation allows minimal opportunity for change of pace activity that promotes interest, interaction, and hopefully fosters clarification and assimilation of ideas by orientees.

In terms of orientation outcomes, any individual involved in orientation activity can attest to the fact that many aspects of any orientation are misperceived, do not seem to take, and are not as effectual as intended. Indeed, there are times it seems that
the orientee emerges from the orientation experience more disoriented than ready to function. This emphasizes the questions of what is amiss in the orientation process.

It is characteristic of the orientation process that one individual gives while the other is placed in the position of passive receiver. Inevitably, this results in passive, uninvolved, or ineffectual learning.

Most effectual learning takes place when one is adequately motivated to learn or when content offered relates specifically to a felt need of the learner for information. There are few orientations that specifically address the felt needs of the orientee. In most new situations, the felt needs of the orientee relate to the nature of the environment in which they will be functioning, the kinds of circumstances with which they be expected to cope, and kinds of people with whom they will be interacting. Behind these kinds of concerns is always some degree of apprehension about whether one will be able to live up to expectations that have been set.

Adequacy of a support system during the whole orientation experience is also significant to the orientee. Needs from the vantage point of the orientee might well be elicited and orientation programming modified to prioritize content in format consonant with the needs of both presenter and receiver. In the absence of felt need for procedural detail, which is typical of most orientees, motivation to learn is absent. How does one assess if the information given during an orientation is meaningful, relevant, and time appropriate for the orientee?

It is helpful to observe carefully the activity of the orientee as he/she begins to function following the orientation process. Most orientees engage in a period of active self-orientation following formal orientation. In observing nursing students released to function in a new clinical situation or environment following an orientation, one notes that there are those who reach first for the procedure book, kardex or chart, others who slowly review the geography of the unit, and a few who disappear promptly, but briefly, into patient rooms. Self-conscious bewilderment is usually obvious in the demeanor of the orientee at this time. Questions may or may not be asked of the orienter, but a renewed "need to know" is apparent.
Self-orientation proceeds with testing or relearning of information imparted during the formal orientation as well as searching for additional information. Errors in protocol are often made in spite of checking and rechecking of procedural detail. However, as each orientee is able to assimilate the new situation in a holistic context, confident effectual activity ensues. The time necessary to achieve a sense of this mastery is variable for orientees with a range from hours, to days and for some, weeks.

When mastery is achieved a sense of control, both self-control and control of situation, is established. Any situation out of one's control, no matter how small, or sense of self not in control, both of which occur in new situations, diminish the capacity to function effectively. A well-planned orientation takes these dimensions into consideration, establishing need for knowledge, then providing information and experience designed to cultivate a sense of mastery and control.

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REFERENCES