

LEADERSHIP FOR NURSING WORK-BASED MOBILE LEARNING

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ABSTRACT

This paper reflects on work-based mobile learning in the Canadian healthcare system for registered nurses' ongoing skills development and continuing professional development. It calls on distributed leadership to address the organizational contextual factors for making this mode of learning sustainable.

KEYWORDS

Work-based mobile learning, nursing, distributed leadership, continuing professional development, registered nurse

1. INTRODUCTION

The emergence of digital technology in the Canadian healthcare system has opened doors to new work-based learning practices for advanced knowledge and skills development. Due to their convenience, portability, and multimedia capabilities, mobile technologies are becoming important vehicles for seamless learning in the workplace, taking learning out of classroom settings for both formal and informal learning. However, the pervasiveness of the workplace context influences the success of work-based mobile learning (WBML). As such, using mobile devices for attaining meaningful learning outcomes must be recognized and driven by leadership. In this paper, the author argues that distributed leadership (DL) could be a viable means to leverage mobile devices for informing work-based pedagogical practices for ongoing skills development and continuing professional development (CPD) of Canadian registered nurses (RNs), and sustaining WBML in their workplaces.

2. CANADIAN REGISTERED NURSES AND WORK-BASED MOBILE LEARNING

In Canada, the regulation of the nursing profession is achieved through self-regulatory mechanisms; whereby, the profession itself is accountable for the competence and the conduct of its members for the benefit and protection of the public (Schiller 2014). As self-regulated professionals, there were 383,949 Canadian diploma- or degree-prepared RNs in 2014, practicing "both autonomously and in collaboration with other health care providers to coordinate health care, deliver direct services and support clients in their self-care decisions and actions in health, illness, injury and disability in all stages of life" (Canadian Institute for Health Information 2015, p.7) Additionally, these RNs must continually enhance their professional knowledge and skills including ensuring their practice is evidence-based (Canadian Nurses Association 2007). However, they are faced with barriers to engage in CPD including time-intensity of courses, difficulty taking time off work, family obligations, finances, fatigue, and struggles with balancing work/study demands (Baxter et al. 2013). Moreover, as self-directed learners, Canadian RNs are seeking out new opportunities to meet their learning needs for maintaining competency and CPD beyond the boundaries of traditional education. This includes the use of mobile technologies as interactive learning tools for RNs to engage in rich learning experiences in their places of work.

WBML has emerged as an innovative and rapidly expanding field of practice combining work-based learning and mobile learning approaches. It is defined as “the processes of coming to know, and of being able to operate successfully in, and across, new and ever changing contexts, including learning for, at and through work, by means of mobile devices” (Pimmer & Pachler 2013, p.194). As these authors suggest, *learning for work* often occurs “off-the-job” in preparation for future application, *learning at work* or “just-in-time” learning happens at point-of-need, and *learning through work* includes the social experiences and learning that connects learners. In the healthcare workplace, mobile devices can supplement face-to-face workplace education/training in a blended approach, or can provide access to eLearning courses for future use. Although WBML does include teacher-led instruction, most work-based learning in the healthcare workplace is informal and self-directed (Wihak & Hall 2011). Mobile devices can be utilized to access online resources including healthcare databases, medical apps/videos, and others for “just-in-time” work-based learning that reduce uncertainties and increases self-confidence when challenged with new situations, procedures, and/or treatments (Fahlman 2012b). Mobiles can also connect RNs for sharing of practical and professional experiences, problem-solving, building mutual understanding, and creating new contexts for collaborative learning in a community of practice. Furthermore, they can provide RNs with alternate modes to actively engage in learner-centered WBML, either individually or collaboratively in real time, synchronously and/or asynchronously. However, learning environments are never static and the common ground of learning is continually shifting (Sharples et al, 2010). Marsick et al, (2011) posit that the organizational context is pervasive, interacting with and influencing learning. As such, the healthcare workplace contextual factors can also constrain and even impede WBML based on the healthcare system norms and goals and also the attitudes and values of the individuals working within it (Burden et al, 2011).

Currently, there is controversy in Canadian healthcare settings as to whether RNs should use mobile technologies in their workplaces; yet these devices can facilitate timely, easy, and convenient access to health information resources for improving patient care and outcomes (Mather & Cummings 2015). Some employers have restricted the use of personal mobiles during work hours or in certain areas of the workplace (Canadian Nurses Protective Society (CNPS) 2013) due to apprehensions that mobile use is disruptive and distracting. These employers perceive that personal tasks and socializing are the only reasons nurses are on their mobiles, rather than using them to access healthcare resources (Eggertson 2012). This has led to RNs expressing trepidation about using their mobiles for their CPD such as:

[An iPad] is not seen as something that you can text on or perform personal things. I think it is big enough that people can see what you are doing. I think that with an iPhone or any other cell phone, it's just automatically assumed that you are texting. It's ok for me to whip out my Kobo [e-Reader] and look up things on it, because it's like a textbook. That's why I actually bring that to work. An iPhone, I wouldn't even dream of [bringing it to the nursing unit] because if I brought it out in front of the wrong person, it might get me in trouble (Fahlman 2012b)

While some healthcare employers may provide RNs with employer-owned mobile devices for clinical use or encourage bring-your-own-device (BYOD) into their workplaces, this complicates security risk management (CNPS 2013). There are concerns about cybersecurity risks and patient privacy issues, vulnerability of mobile devices for loss and theft due to their small size, and the potential for inappropriate access of patient health information by healthcare providers (Burns & Johnson 2015). Additionally, there are connectivity and bandwidth issues especially in Canadian rural and remote healthcare facilities that render difficulties in accessing the Internet and adding costs to users (Fahlman 2012b). Consequently, some RNs are downloading learning resources outside of their work settings to be able access these resources offline in their workplaces (Fahlman 2012b). Infection control issues have also been raised with transporting of mobile technologies across multiple patient rooms (CNPS 2013). While the potential for WBML is promising, “its realization remains vexed and ethically challenging. . . the question remains how to exploit the potential of mobile devices in professional workplace learning while minimizing threats to others” (Burden et al, 2011, p.295). Mobiles can facilitate work-based learning that is contextually sensitive and situationally appropriate for RNs’ ongoing skills development and CPD; however, it calls for leadership that promotes a culture of learning that encourages the professional use of mobile devices and the sustainment of WBML in the healthcare workplace.

3. DISTRIBUTED LEADERSHIP AND WORK-BASED MOBILE LEARNING

For mobile technologies to become the norm and to be valued in healthcare work settings, there needs to be further unveiling of the mobile learning paradox to legitimize mobile devices as learning tools for WBML (Mather & Cummings 2015). Many of those in the chain of command have not changed their thinking about traditional work-based learning due to their inherent need to control the learning process towards certain goals and outcomes (Marsick et al, 2011). Learning-committed leadership is thus paramount for building a learning culture that shifts control to the learner for pursuing individualized goals for skills and CPD within the organizational context (Ellinger 2005; Marsick et al, 2011). As Ellinger (2005) advises, these leaders can have tremendous influence for change on informal work-based learning by creating learning opportunities, serving as developers (coaches and mentors), providing visible support and making space for learning, encouraging risk taking, instilling the importance of sharing knowledge and developing others, and by giving positive feedback and recognition including serving as role models. However, as no one person can have all the requisite expertise to effect major changes in the complex health care workplace, new models of shared and DL are emerging (Canadian Health Leadership Network 2014).

The DL model is a way forward for focusing on leadership that is widely shared among leaders replacing top down, directive, or autocratic styles (Canadian Health Leadership Network 2014). It is characterized by “networking, collaboration, instilling a common vision, allowance for member-leader actions, and empowering members to adopt new paradigms of working” (Jalovicic et al, 2014, p.334). DL works only in teams where members recognize the potential for leadership practice to coexist as a function rather than a position, focusing on maximizing the capacity of people within organizations by concentrating on expertise wherever it exists (Thornton 2010). Palmer et al (2013) suggest that in complex organizational structures where there is the intersection of information technology (IT) systems and the online learning environment, DL may be more responsive to unpredictable and disruptive issues that arise than traditional hierarchical structure. As such, DL in online learning environments can be the means to capitalize on and productively mobilize all individuals enacting leadership within the organization to effectively collaborate and share the vision and responsibility for achieving successful learning outcomes. As mobile learning distributes online learning across various dispersed workplace networks, it can be matched with a distributed strategy of leadership that is also open to flexible networks (Cleveland-Innes et al. 2015).

In the complex healthcare workplace, DL that promotes WBML for RNs will not occur spontaneously. Employers must acknowledge and accept that dispersed leaders are required at all organizational levels to address ongoing learning challenges and realize the potential of WBML for achieving successful learning outcomes. Formal and informal leaders are needed in administration, IT, nursing, education, and other stakeholder groups to co-create and communicate a common vision for WBML implementation that generates mutual trust and respect for meaningful change to occur. It will take time, energy, support, and decisiveness to free up resources for the dispersed leaders to foster a culture of interdependence committed to WBML. This approach requires open communication, validation of concerns, empathy, and active listening to seek different perspectives that inspire the distributed leaders to mobilize expertise and knowledge, establish clear institutional direction and policy, and promote stakeholder engagement in WBML. As Cleveland-Innis et al (2015) argue “it will take conscious, path-breaking policy behaviour to implement systems of distributed leadership – it will not be an organic process” (p.110). There is also a moral imperative that WBML in the healthcare workplace be ethically driven to avoid harm. Hence, clear defensible guidelines, standards, and practices for awareness and understanding of the professionally responsible use of mobile devices based on trust and confidentiality, accountability, and transparency must be developed and implemented to instill ethical, legal, and safe practices (Burden et al, 2011). Correspondingly, policies, protocols, and IT systems must be established for the secure WBML integration to reduce risks and adverse consequences (CNPS 2013). Furthermore, it is crucial that the distributed leaders incorporate evaluation systems to measure and celebrate the successes of the RNs’ WBML for ongoing skills development and CPD in addition to addressing concerns.

4. CONCLUSION

Mobile technologies are not a passing fad, and organizations including the Canadian healthcare system need to realize that they are here to stay and that it's just a matter of time before WBML becomes ubiquitous. Canadian RNs are using this self-directed, learner-centered approach to actively engage in skills development and CPD within their community of practice, regardless of whether their workplaces have organizational structures to pedagogically support this learning. Subsequently, there is a call for leadership that is widely distributed at all organizational levels that creates a clear and compelling vision, supports a sharing culture, and builds trust throughout the complex healthcare system for implementing and sustaining WBML. Moreover, the time seems ripe for healthcare employers to answer this call and make meaningful changes in the healthcare workplace for meeting the learning needs of Canadian RNs.

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