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Acute Care Nurses' Attitudes Toward Nursing Students with Disabilities

Kristy Lynn Calloway

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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

ACUTE CARE NURSES' ATTITUDES TOWARD NURSING
STUDENTS WITH DISABILITIES

A Dissertation Submitted in Partial Fulfillment
Of the Requirements for the Degree of
Doctor of Philosophy

Kristy Lynn Calloway

College of Natural and Health Sciences
School of Nursing

May 2019

This Dissertation by: Kristy Lynn Calloway

Entitled: *Acute Care Nurses' Attitudes toward Nursing Students with Disabilities*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in the College of Natural and Health Sciences in the School of Nursing, Program of Nursing Education.

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ABSTRACT

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The purpose of this study was to describe acute care nurses' attitudes toward nursing students with disabilities, how these attitudes were impacted by the acute care culture, and what significance they had for behavior. No studies have been done within the United States in relation to attitudes acute care nurses hold toward nursing students with disabilities practicing and learning in their clinical settings. In this focused ethnography, semi-structured interviews were conducted with 20 acute care nurses who had at least two years' experience precepting nursing students. While exploring acute care nurses' attitudes toward nursing students with disabilities, six themes emerged: Safety, Barriers, Otherness, Communicating to Meet Needs, Disclosure, and Student Versus Colleague. Data analysis revealed that although there were positive feelings about hosting a nursing student with a disability, thoughts and behavioral intentions were quite negative. It is imperative that the culture of nursing be changed to a more inclusive social model to ensure success for nursing students with disabilities. This need has implications for nursing education, practice, and further research.

DEDICATION

To my Pa and Granny, Joe and Zoe Lee, who fostered a desire for education in all their grandchildren.

To my mom, Susan Dodson, for endless edits, keeping me going, and being my rock.

To my husband, Nathan, for keeping me grounded.

To my children, Clay, Larra, Lindy, Holdin, Gabriel, and Abigail, for being my biggest fans and being with me through every single step.

And last, but far from least, to my granddaughters, Adelaide Joe and Clementine Rainn, for being my sunshine.

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TABLE OF CONTENTS

CHAPTER I. INTRODUCTION.....	1
Introduction.....	1
Statement of the Problem.....	10
Purpose of the Study.....	11
Research Question.....	12
Significance of the Study.....	12
Operational Definitions.....	13
Overview of the Study Design and Methods.....	14
Conclusion.....	14
CHAPTER II. REVIEW OF LITERATURE.....	16
Introduction.....	16
Search Strategy.....	16
Focusing the Review of Literature.....	18
Concepts Defined.....	19
Theoretical Framework.....	23
Experiences of Postsecondary Students with Disabilities.....	26
Experiences of Nursing Students with Disabilities.....	33
Nurses with Disabilities in the Clinical Setting.....	38
Nursing Students with Disabilities in the Clinical Setting.....	44
Conclusion.....	55
CHAPTER III. METHODS.....	57
Introduction.....	57
Restatement of the Research Question.....	57
Participant Selection.....	58
Methods Selection and Research Design.....	58
Data Collection Procedure.....	61
Data Analysis Procedure.....	63
Assumptions.....	67
Limitations.....	67
Delimitations.....	67
Establishing Rigor.....	68

Ethical Considerations	70
Conclusion	71
CHAPTER IV. FINDINGS	73
Participants.....	73
Defining Disability.....	74
Thematic Findings	75
Themes Related to Attitude	85
Summary.....	86
CHAPTER V. DISCUSSION.....	87
Findings Related to the Theoretical Framework.....	97
Findings Related to the Research Question	97
Limitations	99
Implications.....	99
Summary.....	102
REFERENCES	103
APPENDIX A. PERSONAL INTEREST IN DISABILITY STUDIES	119
APPENDIX B. INSTITUTIONAL REVIEW BOARD APPROVAL.....	122
APPENDIX C. LETTER OF INVITATION TO PARTICIPATE.....	124
APPENDIX D. CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH	127
APPENDIX E. DEMOGRAPHIC INFORMATION.....	130
APPENDIX F. SEMI-STRUCTURED INTERVIEW PROTOCOL.....	132

CHAPTER I

INTRODUCTION

Introduction

Society's accumulated myths and fears about disability and disease are as handicapping as are the...limitations that flow from actual impairment--
William J. Brennan, Jr. (cited in Association for Higher Education Access and Disability, 2009)

It is likely you know or work with someone who has a disability, or you may have a disability yourself. The Centers for Disease Control and Prevention (CDC; 2014) estimated there are approximately 74 million individuals with disabilities in the United States. In addition, approximately 10% of licensed nurses have some type of disability (Bemis, 2009). Even though disability rights were part of the civil rights movement of the 1960s, change and acceptance for this population has been gradual. Nursing is positioned to lead the change for inclusion of individuals with disabilities in the workforce. The Institute of Medicine (IOM) has mandated an expansion of the diversity of the nursing workforce to meet the needs of our diverse population (Marks & Ailey, 2017). To expand the diversity of the workforce, we must first expand diversity in schools of nursing by accepting and educating more students with disabilities. According to Neal-Boylan, Marks, and McCulloh (2015), stakeholder attitudes are one of four areas that impact nursing student success for students with disabilities. Understanding how these attitudes were formed, how they are impacted by the culture of nursing, and how

they influence nurse behavior is a step toward increasing inclusivity for nursing students with disabilities.

Section 504 of the 1973 Rehabilitation Act

The first disability civil rights law to be enacted in the United States was Section 504 of the 1973 Rehabilitation Act. It was part of the initial civil rights movement of the 1960s in the United States. Section 504 prohibited discrimination towards people with disabilities in programs that received federal financial assistance (Disability Rights Education and Defense Fund, 2016). It defined disability as, “a physical or mental impairment that substantially limits one or more major life activities; a record (or past history) of such an impairment; or being regarded as having a disability” (Americans with Disabilities Act [ADA], 2014, p. 1). Although it was a part of the civil rights movement and the law was enacted, things did not immediately begin to change for individuals with disabilities.

The Americans with Disabilities Act of 1990

It was not until the late 1980s that attention began to turn to disability rights. In 1988, deaf students of Gallaudet University in Washington, D.C. held a week-long protest “calling for the appointment of a deaf university President” (Minnesota Governor’s Council on Developmental Disabilities, 2017). For the next two years, the ADA was in process of gaining governmental approval. In March of 1990, after passing the Senate, it stalled in the House Committee on Public Works and Transportation. This was the impetus for the protest at the Capitol that led to the “Capital Crawl.” Over 60 protestors put aside their assistive devices and crawled up the Capitol’s 78 marble stairs

on the West Front to illustrate the struggles faced by individuals with disabilities on a daily basis (Minnesota Governor's Council on Developmental Disabilities, 2017). Later that year, the ADA of 1990 was passed, granting individuals with disabilities rights they had never had to this point. Under the ADA of 1990, discrimination in employment, public services, public accommodations, and telecommunications was prohibited toward individuals with disabilities, and they were guaranteed the same rights as everyone else to participate in mainstream American life (U.S. Equal Employment Opportunity Commission [EEOC], 2005).

Americans with Disabilities Act Amendment Act of 2008

In 2008, the Americans with Disabilities Act Amendments Act (ADAAA) broadened the original definition of disability to increase inclusivity. It expanded the definition of the major life activities. Consequently, the ADAAA of 2008 defines *major life activities* as including but not limited to

caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working, [in addition to] the operation of a major bodily function, including...functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. (§ 4, a, 2, A, B, 122 Stat. 3553, 3555; Dupler, Maheady, Fleming, & Allen, 2012, p. 141)

This was not a part of the original ADA of 1990. The indication of "limited" major life activities is defined by comparing to the level of function of the general public. Another new addition is that short term or episodic impairments (such as pregnancy complications, cancers in remission, etc.) are also considered a disability, where under the ADA of 1990 the impairment had to be permanent (Dupler et al., 2012). These expansions in the definition of disability in the ADAAA allow for a greater number of

individuals with disabilities to qualify for services which increases their ability to participate in mainstream American life including the educational and job markets.

According to Dupler et al. (2012), Congress stated in the ADAAA of 2008:

Physical or mental disabilities in no way diminish a person's right to fully participate in all aspects of society, yet many people with physical or mental disabilities have been precluded from doing so because of discrimination; others who have a record of a disability or are regarded as having a disability also have been subjected to discrimination. (§12101, a, 1; p. 141)

In addition, the Act states that the "definition of disability shall be construed in favor of broad coverage of individuals under this Act, to the maximum extent permitted by the Act" (Dupler et al., 2012, p. 141). The ADAAA mandate to define disability as broadly as possible shifted the focus from the disability of the individual to the institution's response for accommodation and whether or not it was discriminatory, thereby shifting the focus from the physical aspects of disability to the social and environmental issues (Neal-Boylan & Miller, 2015, 2016). Utilizing the broad interpretation intended by Congress along with the limitations to interpret statutorily placed on the court system, individuals may find more protection under the ADAAA of 2008 than they did in the past (Dupler et al., 2012; Neal-Boylan & Miller, 2015).

Significance of the Population

Individuals with disabilities form the largest and most diverse of all minority groups worldwide (Rochette & Loiseau, 2012). According to the World Health Organization (WHO; 2016), about 15% of the world's population has some form of disability and rates of disability are increasing due to the aging population, increases in chronic health conditions, and other causes. It was reported by the U.S. Census Bureau (2010) that 9.9% (19.5 million people) of the United States working age population has a

disability. Studies report that only 19% of individuals with disabilities are employed compared to 64.5-77% of the general population (Fraser, Ajzen, Johnson, Hebert, & Chan, 2011, p. 1; Siperstein, Romano, Mohler, & Parker, 2006, p. 3). The sheer size of this population of working-class people is significant.

Nurses with Disabilities

In 2003, the Rush University College of Nursing Symposium on Nursing Students with Disabilities was held and initiated two important factors influencing nurses with disabilities (Marks & Ailey; 2017). First, an open, expert forum was held to discuss the value of nurses with disabilities and also, the National Organization of Nurses with Disabilities was formed (Marks & Ailey, 2017). This began the process of giving voice to nurses with disabilities.

The Job Accommodation Network (JAN; 2011) reported that there will be over one million job openings in nursing between 2008 and 2018 due to market growth and replacement needs. It would be important to consider the number of nurses with disabilities in the United States to meet this need. Although many nurses do not disclose disabilities, Bemis (2009) reported that there are approximately 290,000 nurses with disabilities. Many of these nurses have been considered unemployable because employers are hesitant to hire nurses with disabilities for fear of liability or cost of accommodations. It is significant to note that there has been no documentation demonstrating that care provided by a nurse with a disability has ever compromised patient care or safety due to the disability (Neal-Boylan, Fennie, & Baldauf-Wagner, 2011). To address the gap between employers' perceptions and the realistic needs of nurses with disabilities, the JAN published the "Accommodation and Compliance Series:

Nurses with Disabilities” document to assist employers in determining effective accommodations for nurses with disabilities.

Barriers for Nursing Students with Disabilities

Now that the extent of this population and the role they could play in nursing is understood, what barriers exist for educating nursing students with disabilities? Research indicates that admitting and accommodating students with disabilities into schools of nursing is a significant step toward the acknowledgment of their importance as part of the nursing profession. Yet, there are still many barriers to overcome in the education of nursing students with disabilities.

Neal-Boylan et al. (2015) identified four areas that require change to aid in nurse and student success: “policy, education, stakeholder attitudes, and practice” (p. 11). Change in these areas for nurses and nursing students with disabilities will aid in meeting IOM’s mandate to “expand the diversity of students, faculty, workforce, and researchers to meet the demands of a culturally diverse population across the lifespan” (Marks & Ailey, 2017, p. 1).

Policies within nursing programs and clinical facilities have a significant impact on the acceptance and success of nursing students with disabilities. Under the Rehabilitation Act of 1973, a list of basic job duties that an employee must be able to perform with or without reasonable accommodations was established; these were called essential functions (EEOC, 2005). Many employees have used these essential job functions to exclude individuals with disabilities. In education, these are often referred to as “technical standards” and have been used to exclude students with disabilities from entering nursing and other programs that require licensure (Marks & Ailey, 2017).

Likewise, Neal-Boylan (2014) found most facilities use a generic job description and essential functions that are not tailored to the work of the specific job.

Education is the key to either encouraging open-mindedness and acceptance or propagating negative attitudes toward students with disabilities. One significant barrier is the framework on which many of our schools of nursing still rely. The medical model, that has long been a tenet of our practice, leads to discrimination against students with disabilities. The medical model identifies disability as a “deficit” which should be “fixed”, treated, or managed similar to illness rather than as a social issue that should be accommodated (Carol, 2002; Marks & Ailey, 2017; May, 2017; Northway, 2000; Wright & Eathorne, 2003). This historic view of disability leads to difficulty in admitting and progressing students with disabilities. Graduates from nursing programs that subscribe to these ideas have been imbued with a negative or, at minimum, an apathetic attitude toward disability. In addition, the misconception that educators are responsible for the employability of graduates instead of educating competent nurses is another point to consider (Andre & Manson, 2004). Employment rates are important for accreditation and university reporting and funding, and educators often give thought to “potential future difficulties” (Evans, 2014). While this creates, for the school of nursing, a sort of balancing act between accommodating for disabilities and meeting the requirements of the accrediting agencies and governing organizations, these are not valid reasons for not admitting or accommodating qualified, competent nursing candidates with disabilities.

The focus placed on acute care practice in nursing education limits the experiences available to some nursing students with disabilities. The Carnegie Foundation (cited in Benner, Sutphen, Leonard, & Day, 2010) led a study of the current

landscape in nursing education that was published as the book *Educating Nurses: A Call for Radical Transformation*. Along with other recommendations, one was “considering that more than half of nurses work outside of hospitals, nurses must be prepared for a variety of different clinical settings, and their clinical time should not be focused just on acute care” (Benner et al., 2010, p. 85). Faculty have to evaluate how they measure each clinical objective and whether it can be safely met through an alternative assignment. Modifying the clinical practice focus to be more inclusive of all areas of nursing and utilizing alternative experiences, such as simulation, could open the door for students with disabilities to have a greater opportunity to fulfill clinical obligations in schools of nursing when they are unable to practice in an acute care setting (Rankin, Nayda, Cocks, & Smith, 2010). In addition, providing options of clinical and non-clinical tracks in nursing would allow all students to maximize their strengths and lower the potential impact of disability on job-related tasks (Neal-Boylan et al., 2011).

The last, and most impactful, barrier to student success is attitude. One of the most discussed obstacles to the success of students with disabilities among faculty and in the literature is the perception of students being unqualified for admission or unsafe in the practice setting. As discussed previously, the original ADA of 1990 allowed the adoption of essential functions for employment and technical standards for education (Dupler et al., 2012). The difficulty with this allowance was these lists were misconstrued as exclusionary instead of being used as a guide for accommodations as the ADA intended (Carol, 2002). Sin and Fong (2007, 2008) indicated this blanket approach of general fitness requirements must be rescinded. Neal-Boylan (2014) also emphasized that many nurse educators hold to the traditional emphasis in nursing on physical ability instead of

being open to how tasks could be accomplished due to advances in technology or with the help of others. Great inconsistencies have been identified in the way schools of nursing utilize these requirements and admit students with disabilities as well (Sin & Fong, 2008). While studies have shown some faculty continue to hold historic attitudes toward nursing students with disabilities, education increases their willingness to accommodate nursing students with disabilities and promotes positive perceptions (Ashcroft et al., 2008; Milligan, 2010; Sowers & Smith, 2004a, 2004b). Unfortunately, attitudes of acute care clinical practice partners toward nursing students with disabilities have not been studied and are a significant factor in the success of this student population. A significant point of discrimination for students with disabilities has been clinical or field placement (Andre & Manson, 2004). Once a student with a disability is admitted into a nursing program, there is often a perception of the student being unsafe in patient care settings due to the differences in the way they perform skills or the time they take to do certain procedures (Carol, 2002; Carroll, 2004). While safety is of utmost importance in nursing care, it is vital to avoid blanket generalizations and deal with students on a case-by-case basis (Persaud & Leedom, 2002). It is important to note that there is no documentation that shows nurses with disabilities are more unsafe than other nurses or threaten patient care due to the disability (Neal-Boylan et al., 2011). Just as some nondisabled students are not safe in clinical practice, there are certainly students with disabilities who are unsafe but in the interest of human dignity and culturally competent care, we must not make those generalizations based on disability alone. Many in the practice setting overestimate the impact of the disability rather than seeking to understand the compensatory technique to practice safely (Neal-Boylan, 2012). Doing

something differently does not make it wrong but the current practice setting is very narrow in its interpretation of the right way to do procedures. It is important to note that Section 504 and the ADAAA do not mandate clinical sites to provide accommodations for students with disabilities as they are not employees (Neal-Boylan & Miller, 2017). According to Rankin et al. (2010), addressing this issue involves clinical facility as well as the school of nursing and requires a great deal of open communication between all parties involved.

All of the aforementioned barriers relate to attitudes toward nursing students with disabilities. In all scenarios, negative attitudes toward nursing students with disabilities lead to marginalization and discrimination. Unfortunately, given their significant role in educating nurses with disabilities, incredibly little research has been done addressing acute care nurses' attitudes toward nursing students with disabilities.

Statement of the Problem

In light of the identified barriers for nursing students with disabilities, we must address the one area that has remained relatively untouched--acute care nursing. Acute care nurses play a vital role in each student's experience and success in schools of nursing and this is no different for students with disabilities. The disadvantage for students with disabilities is the fear of unsafe practice and lack of knowledge about the ADAAA and disability law. This lack of understanding typically leads to either a negative attitude toward these students or an overcompensation in accommodation that causes increased feelings of marginalization by the student. Either way, understanding clinical nurses' attitudes toward students with disabilities and finding ways to address those attitudes is key to meeting the needs of nursing students with disabilities.

Much of the research that has been conducted on students with disabilities is not current. More specifically, most of what has been researched concerning nursing students with disabilities was conducted in the United Kingdom, Australia, and Canada. Little recent research was found on this subject from the United States. In addition, research that focused on clinical partners' attitudes toward nursing students with disabilities was almost nonexistent. One article from Australia was the only one discovered that addressed the perceptions of healthcare organizations specifically (Rankin et al., 2010). This area of research has been overlooked but is an essential part of educating nursing students with disabilities. Without real-world experiences provided by our clinical partnerships, schools of nursing would be unable to produce competent graduate nurses.

Purpose of the Study

The purpose of this study was to understand acute care nurses' attitudes toward nursing students with disabilities by using a focused ethnography. A dearth of research exists concerning nursing and disability. While interest has increased in recent years and more research has been done, the area overlooked to this point was clinical facilities who host schools of nursing. Acute care nurses are an important part of educating nursing students and positive clinical experiences are vital to success in the nursing profession.

The social constructionist paradigm indicates the dominant ideas, attitudes, and customs of society influence the perceptions of the individual. From this view, the social model of disability states that disability is a product of society, the culture, and the environment. In addition, individual attitudes are impacted by society, the culture, and the environment. Therefore, a focused ethnography studying the specific issue of

attitudes toward nursing students with disabilities in the environment of acute care nursing would open the door for dialogue and further understanding of accommodating nursing students with disabilities within the clinical setting.

Research Question

This study asked the following research question and sub-questions:

- Q1 What are acute care nurses' attitudes toward nursing students with disabilities?
 - Q1a What beliefs do acute care nurses hold about nursing students with disabilities?
 - Q1b What feelings do acute care nurses have about nursing students with disabilities?
 - Q1c What behavioral intentions do acute care nurses have for working with nursing students with disabilities?

Significance of the Study

A scarcity of information has focused on acute care nurses' attitudes toward students with disabilities. We must seek to fully understand and address barriers nursing students with disabilities might encounter in schools of nursing. Clinical partnerships are instrumental in effectively educating nurses. Understanding the attitudes acute care nurses hold regarding nursing students with disabilities would help faculty in providing the most valuable and safe clinical experiences for students while meeting the needs of the students and the clinical partner. This knowledge begins with recognizing the attitudes of acute care nurses toward nursing students with disabilities.

The primary purpose of all schools of nursing is to accept and graduate safe, qualified, competent nurses. Furthermore, there is motivation to diversify the nursing workforce by being more inclusive. Since individuals with disabilities are the largest and

most diverse minority group in the world, it would behoove the nursing profession to seek ways to support their success (Rochette & Loiselle, 2012). Because of this need and the lack of previous research, it was important to gain an understanding of clinical nurses' attitudes toward nursing students with disabilities.

The results of this study would be significant by making a contribution to the understudied area of acute care nurses' attitudes toward nursing students with disabilities. This knowledge and understanding could provide insight to the profession of nursing, to institutions, to individual schools of nursing, and to clinical facilities for better addressing the needs of students with disabilities.

The minute amount of research performed specifically addressing disabilities within nursing was either outdated or primarily conducted outside of the United States. This study addressed new regulations and policies not in place when many of the initial disability studies were completed. It also was specific to the United States since every country might differ in disability law.

Operational Definitions

Attitude. Evaluative judgments based on beliefs (thoughts), feelings, and behavioral intentions.

Acute care nurse. A nurse in a healthcare facility with at least two years' experience precepting students in the acute care setting.

Disability. A complex phenomenon involving an individual and the way society influences the individual's experiences in life.

Nursing student with a disability. A student enrolled in nursing program who has a physical, mental, or learning disability, as described above, whether or not they have disclosed such a disability.

Overview of the Study Design and Methods

This study used a focused ethnographic design. The volunteer sample for this study was recruited from past graduates of two schools of nursing in two south-central states who have precepted students in the acute care setting for a minimum of two years.

Initial participants were recruited through a purposeful and opportunistic method by sending an emailed letter of invitation for participation in the study to all past graduates of two schools of nursing. In addition, those who responded were asked to forward the letter of invitation for participation to other nurses who might qualify for the study. All participants were provided contact information for the researcher, a consent form, and explanation of how the study would be conducted. The researcher then scheduled with consenting participants to record interviews either in person or via phone-conferencing. Data were analyzed and interpreted using framework analysis with the assistance of Microsoft Office computer software.

Conclusion

Individuals with disabilities have had to fight a long and uphill battle for equal rights in the United States. The most recent piece of legislation, the ADAAA of 2008, has expanded the definition of disability and focused more on inclusivity (Dupler et al., 2012). In recent years, contributions of individuals with disabilities to nursing practice have been realized but some historic views as well as continued concerns about patient safety still remain. Studies that have been conducted have focused primarily on non-

nursing students and faculty. While this information is important, it is also valuable to understand issues facing nursing students in the clinical setting due to the unique nature of the profession. Since we are beginning to understand the perceptions of nursing faculty regarding nursing students with disabilities, it is important to look at the next significant piece of the nursing education puzzle--clinical partners. Understanding acute care nurses' attitudes would lead to further steps that could be taken to provide equity for students with disabilities in schools of nursing.

CHAPTER II

REVIEW OF LITERATURE

Introduction

A review of literature is an integral part of the research process. It is essential to understand previous work so new studies can address gaps and advance previous research (Randolph, 2009). The literature review process is similar to conducting primary research. Randolph (2009) made the correlation through the following key components: (a) a rationale for conducting the review, (b) research questions or hypotheses that guide the research, (c) an explicit plan for collecting data, (d) an explicit plan for analyzing data, and (e) a plan for presenting data. Suggestions from Randolph were used to guide this review of literature.

Organization of the review of literature also followed Randolph's (2009) suggestion. The introductory section describes the process of the review and the guiding framework. The design consists of a conceptual and historical format followed by a discussion of the results. A summary of results identifying the gaps in literature and needs for further research concludes the review of literature.

Search Strategy

Since interest was piqued on the topic of nursing students with disabilities in 2010, literature searches were performed at varied intervals and articles were saved on an external hard drive and categorized by author, date, and title. The following terms were

used in the literature search in various combinations: attitudes, social model of disability, faculty, nursing faculty, disabilities, students with disabilities, nursing students with disabilities, nurses, clinical facilities, and clinical. Databases searched were Summon, CINAHL, Academic Search Premier, and Proquest Dissertation and Theses, Psychinfo, and PubMed utilizing University of Northern Colorado and East Central University libraries. Internet searches were utilized to access articles not available through the databases listed. Initial searches were exhaustive without limiters for date or publication. Much of what was found were editorials. Articles were retrieved either by full text from the database or interlibrary loan. Books were not excluded but the only books located dated back over 30 years; while providing good historical context, they did not contribute to the current literature as regulations, laws, and culture have changed dramatically since the ADA of 1990.

New sources were harvested from the reference lists of found articles and dissertations. These were obtained and reviewed until saturation was achieved. Additional searches were conducted utilizing the above criteria to identify any new articles relevant to this review of literature. This search did reveal several current articles that were included in the literature review. These articles were also saved to the external hard drive.

After all articles were saved, a spreadsheet was developed to compile and compare the articles. Polit and Beck (2012) suggested the use of such a matrix to make the copious amounts of information more manageable. The spreadsheet contained the author, date, type of publication, type of research, country, and a brief annotation about

the source. Randolph (2009) suggested focusing the literature by developing criteria for inclusion and exclusion guided by questions to be answered by the review of literature.

Focusing the Review of Literature

The first step in focusing the review of literature was to determine what questions the researcher would like to have answered by the review of literature. The researcher identified the following questions that helped focus the literature review for this study:

1. What are students with disabilities' experiences in higher education?
2. What are nursing students with disabilities' experiences in higher education?
Do they differ from non-nursing students?
3. What are nurses with disabilities' experiences in the workplace?
4. What are nursing students with disabilities' experiences in clinical facilities?
5. What are clinical nurses' attitudes of nursing students with disabilities in clinical facilities?

The development of inclusion and exclusion criteria was an important step in focusing the review of literature. Studies were included in the review of literature if they met the following criteria:

- Primary sources--original, peer-reviewed, and published research articles including theses and dissertations
- Secondary sources--meta-analyses, systematic reviews, agency reports, legal reports, and editorials

Studies were excluded from the review of literature if they met the following criterion: studies focused on primary/secondary education due to differences in educational laws regarding primary/secondary school and higher education.

According to Randolph (2009), coverage of the data collection might vary depending on the intent of the study, the goal of the researcher, and the amount of literature available. Due to the paucity of literature on the topic of nursing students with disabilities, a semi-exhaustive review was performed. All published works were considered in this literature review along with pertinent agency and legal reports and editorials related to the topic of disability.

Concepts Defined

According to Walker and Avant (2011), identifying the defining characteristics is the “heart of the concept analysis” and provides the “broadest insight into the concept” (p. 168). For this study, it was important to understand the concepts of disability and attitudes.

Disability

The definition of disability has evolved and changes in disability law have impacted the workforce and higher education. Defining characteristics of disability typically fall into three main categories: individual attributes, social attributes, or a combination of both.

Individual attributes are the focus of the medical model of disability. This model defines disability as “a diagnosis directly caused by an individual’s disease, trauma or other health problems” (Raman & Levi, 2002, p. 791). The ADAAA of 2008 further explains the individual attribute as being either a physical or mental impairment “substantially limiting one or more major life activities” (Symons, Fish, McGuigan, Fox, & Akl, 2012, p. 251). Maheady (1999) used the definition of “visual, auditory, or physical impairment” (p. 163). Guzman et al. (2011) took a somewhat different but still

individual stance stating, “Disability means feelings of powerlessness and loss of one’s ability to function optimally” (p. 273). If considering only the individual attributes of disability, it is difficult to think of someone who is disabled being an employable, contributing member of society. As a matter of fact, some studies reported individuals who were disabled might be considered by others as incapable of making their own choices or decisions (Guess, Benson, & Seigel-Causey, 2008). Increasing the disparity in this group was the fact many medical professionals and practitioners held these beliefs (Symons et al., 2012). Interestingly, nursing students had a greater tendency to hold negative attitudes toward individuals with disabilities than did other health professionals and beginning clinical practice was found to cause even more negative attitudes (Tervo, Palmer, & Redinius, 2004). Attitudes of health professionals are critical to the quality of life of individuals with disabilities. A negative attitude stemming from the individual attribute focused affects much more than just the single encounter. It has implications for the behavior of the health professional, the client, and society (Beckwith & Matthews, 1995). Negative attitudes support negative or low expectations and might influence other healthcare professionals (Beckwith & Matthews, 1995; Tervo et al., 2004).

Social attributes do not focus on the individual but on the way society, culture, and the environment contribute to a disability (Grassman, Holme, Larsson, & Whitaker, 2012). While this approach does not deny an individual impairment exists, the social approach posits the disability is primarily a socially-created problem (Raman & Levi, 2002). Eisland (cited in Yong, 2011) suggested individuals with disabilities need not a cure or healing but “a more just, inclusive, hospitable world” (p. 168). The essence of the social approach places the blame for any disparity on the shoulders of society and works

to remove the stigma of having an impairment. In this view, “disability is attributed to harsh social and physical environments that face persons who are different from the established norms in society” (Raman & Levi, 2002, p. 792). Goggin (2009) expressed this in his definition of disability as “what happens to people with impairments in their encounters and dwelling in society and the world” (p. 492)

Many definitions of disability currently combine individual and social attributes. The most popular of these is the World Health Organization (2016) definition. It defines disability as a “complex phenomenon” involving both an individual and the way society influences the individual’s experiences in life (Symons et al., 2012, p. 251; Yagmurlu, Yagmurlu, & Yilmaz, 2009, p. 638). The social model of disability does not deny a physical characteristic of disability but focuses on impeding factors placed on the individual by society, culture, and the environment (Raman & Levi, 2002). This definition was the most inclusive and kept the focus on social factors that influenced individuals with disabilities.

Attitudes

Attitudes have been studied in the social sciences for decades. The definition has changed over the years and its relationship to behavior has been evaluated (Guyer & Fabrigar, 2015). While attitude is a term with which we are all familiar, it has proven challenging to define concisely as a concept. In the context of this study, the definition of attitudes was evaluative judgements based on beliefs (thoughts), feelings, and behavioral intentions (Bogart, Logan, Hospodar, & Woekel, 2018; Guyer & Fabrigar, 2015).

Attitudes are an evaluation of an object of thought. This evaluation is based on a positive to negative continuum (Ajzen, 2001; Altmann, 2008; Bohner & Dickel, 2011;

Guyer & Fabrigar, 2015; Shrigley, Koballa, & Simpson, 1988). How the brain makes these evaluations is greatly debated. Fazio and Towles-Schwen (1999) argued that attitudes are developed from stored evaluative associations in memory. More recently, Schwarz (2007) and Conrey and Smith (2007) claimed that evaluation judgements are made within a specific situation and are not lasting “things” stored in memory.

Alternatively, Petty, Briñol and DeMarree (2007) developed the meta-cognitive model (MCM), which aligns with both of the other views in that they posit objects could be held in memory and linked to evaluations as Fazio and Towles-Schwen described but could also be influenced by specific situations, the currency of the links, and the context. In addition, they argued that people can “tag their evaluative associations” and hold them with varied levels of confidence based on their individual metacognition (Petty et al., 2007, p. 663). The MCM gives broad and inclusive insight into how evaluative judgments are formed in the context of attitudes.

Historically, attitudes have been defined as comprising beliefs, feelings, and behaviors but recent studies have shown attitudes and behaviors might not always be relatable (Guyer & Fabrigar, 2015). For example, an individual might think and feel cake is bad for them and intend not to have any but still eat it at a friend’s party. In this case, the behavior does not match the attitude.

Beliefs are the cognitive assessment of an object’s attributes (Lavine, Thomsen, Zanna, & Borgina, 1998) and form the cognitive framework for attitudes. “Beliefs provide us factual and nonfactual information” (Shrigley et al., 1988, p. 676). Exposure to an object guides information processing and develops a way of thinking or belief about the object.

Feelings are emotions the object arouses within us (Lavine et al., 1998). They drive the polarity of opinion on the attitude spectrum (like-dislike; good-bad). Lavine et al. (1998) identified that attitudes based on strong feeling are held with greater confidence than those based primarily on cognition or ambivalent feelings.

Bogart et al. (2018) identified behavioral intentions as a measure of attitude. As stated previously, attitude and behavior are not always congruent. Therefore, looking at behavior intention is a better measure of attitude than is actual behavior, which might be influenced by many outside sources and pressures. Ajzen and Fishbein (1980) in their theory of reasoned action described behavioral intention as twofold: behavioral belief (What do I believe?) and subjective norms (What do others think I should do?). In this context, an individual's beliefs and feelings are combined with societal influence to determine an individual's response to an object. An individual's attitudes are primarily learned and social/cultural influence is integral to this learning (Hampton, 2017; Kelman, 1974; Shrigley et al., 1988).

Attitudes, viewed from a constructionist perspective, might be linked in memory but are based more strongly on specific situations and context (Schwarz, 2007). These attitudes consist of beliefs, feelings, and behavioral intentions, creating evaluative judgments about an object to which the individual has been exposed. Social and cultural influence can have a significant effect on an individual's attitudes.

Theoretical Framework

An introduction to the models of disability was discussed above as disability was defined. In reviewing information related to the study of disability and its theoretical frameworks, it was apparent one of two models was typically utilized: a medical or

individualistic model, or a social model of disability. While both serve a purpose in understanding and guiding the study of disability, this study was based on the social model of disability.

The social model does not deny the existence of impairments and physiological differences...; rather, it addresses them without attaching value judgments such as ‘normality’ and shifts emphasis towards those aspects of our world that can be changed. (Priestly, 1998, p. 85)

The social model of disability locates disability within society and the environment instead of within the individual. *Impairment* is acknowledged within the social model as a physical, psychological, or learning issue that is either acquired or congenital (Haegele & Hodge, 2016; Kattari, Lavery, & Hasche, 2017). *Disability* is socially, environmentally, or culturally imposed on the individual with an impairment (Taylor, 2005). Dirth and Branscombe (2017) classified disability as a social issue, stating there is nothing “inherent in impairment worthy of prejudice and discrimination” (p. 416). The social model focuses attention on culture, society, and the environment including attitudinal barriers faced by individuals with disabilities. It posits these factors actually create disability by making it more difficult for individuals with impairments to feel good about themselves (Goering, 2015). In essence, the social model states that while people might have physical, psychological, or intellectual impairments, society failing to accept and accommodate them creates the disability.

Therefore, the concept of disability is a socially-constructed phenomenon (Reid-Cunningham, 2009). Gabel (2010) identified two versions of the social model of disability: material and cultural. The material view focuses on environmental issues that create barriers for individuals with disabilities. The cultural stance posits social structures alone create disability (Anastasiou & Kauffman, 2012). Young (cited in

Priestly, 1998) also used the term *cultural imperialism*, meaning “universalization of a dominant group’s experiences and culture, and its establishment as the norm” (p. 87). It could be argued the cultural view of the social model of disability could affect and change the material view and was therefore the most impactful (Anastasiou & Kauffman, 2012; Priestly, 1998).

Although the social model of disability has been in use for more than 30 years, Oliver (2015) stated it has barely made a dent in equality for individuals with disabilities. Attitudinal barriers are a contributing factor to this phenomenon (Anastasiou & Kauffman, 2012; Dirth & Branscombe, 2017; Goering, 2015; Haegele & Hodge, 2016; Kattari et al., 2017; Rothman, 2010). This lack of equality is in direct relation to a culture that has propagated negative attitudes toward individuals with disabilities (Anastasiou & Kauffman, 2012). Haegele and Hodge (2016) and Anastasiou and Kauffman (2012) pointed out that by changing social structures and attitudes, most barriers for individuals with disabilities would disappear. Dirth and Branscombe (2017) went on to point out that environmental inaccessibility is simply a physical manifestation of negative attitudes of the dominant culture.

Unfortunately, the medical profession tends to be one of the most powerful cultural barriers to the inclusion of individuals with disabilities and is responsible for a large portion of discriminatory practices due to reliance on the medical model (Scullion, 2010). Tervo et al. (2004) identified nurses as having significantly more negative attitudes toward individuals with disabilities than other health professionals. Anastasiou and Kauffman (2012) stated, “Medical professionals are trapped in their social roles as experts and, at the same time, as oppressors of people who have disabilities” (p. 139).

While less oppressive than the medical model, a few weaknesses are worth noting in the social model of disability. In her study of the social model of disability and individuals with chronic fatigue syndrome, Taylor (2005) identified one of the primary shortcomings of the social model by acknowledging that disability does, oftentimes, carry with it a measure of physical or psychological suffering and a sense of negativity. She continued by calling this experience a “neutral human difference,” which might cause the social model to “draw too narrow a conceptualization of disability” (p. 498). In addition, Scullion (2010) stated the social model might oversimplify the reality of disability. While taking these arguments into consideration, the social model of disability remained the chosen framework for this study. The impact of the oppressive medical model in the culture of higher education, nursing, and the clinical environment affects nursing students with disabilities. Movement toward a social model of disability in these three cultural areas could change the experiences and success of nursing students with disabilities.

Experiences of Postsecondary Students with Disabilities

Carney et al. (2007) conducted a survey and in-depth interviews asking postsecondary students how well colleges were meeting the needs of students with disabilities and how those students perceived their experiences. The survey results indicated that one-third of the 39 respondents reported support for transition from high school to college was poor and felt they were not familiar with disability laws so they could advocate for themselves (Carney et al., 2007). Sixty-three percent of respondents disclosed their disability at the beginning of the semester but 45% reported a negative faculty response (Carney et al., 2007). In the interviews, students felt the need for more faculty development. They perceived that if professors were more confident about

disability laws, then negative reactions would decrease (Carney et al., 2007). Less than half the students interviewed felt instructors were aware of and sensitive to disability rights or were providing appropriate accommodations, demonstrating the need for instructors to be educated regarding disability rights (Carney et al., 2007). Unfortunately, they found poor reactions from the professors related directly to students' feelings about the university as a whole (Carney et al., 2007). There were some weaknesses in this study: (a) the sample size was limited and only consisted of students from one university, thereby being potentially biased; and (b) the survey and interview results were not compared. Overall, however, it did illustrate some primary concerns of students with disabilities in higher education.

In 2009, Petrie, Power and Swallow performed an international study of students with disabilities and professionals, both faculty and staff, who supported them. They surveyed a large sample of college applicants from over eight countries on the availability of alternative format and enhanced materials (Petrie et al., 2009). Alternative format materials were audio recordings, Braille transcription, digital accessible information system format recording (an alternate to audio recording that allows for better navigation and searching), and tactile or raised versions of images and graphics (Petrie et al., 2009). Enhanced materials consisted of audio descriptions of video materials, large print/high contrast versions of text or graphic materials, sign language interpretation, and text captioning (Petrie et al., 2009). Student participants rated the availability of all alternative formats and enhanced materials as lacking and only audio descriptions, audio recordings, and large print had statistically better than average availability (Petrie et al., 2009). None of the alternatives or enhancements were reported

as readily available by professionals (Petrie et al., 2009). While this could be due to lack of knowledge of resources available, it still demonstrated a lack of support for students with disabilities. Petrie et al. pointed out the primary finding was a lack of tactile material for blind or low vision students. The article introduced various options to meet the tactile needs for this particular student population. The main weakness of this study was although participants were recruited internationally, they were overwhelmingly representative of the United Kingdom. This article demonstrated an international deficiency in availability (or knowledge of availability) of resources for students with disabilities.

In a study conducted in the United Kingdom in 2010, Vickerman and Blundell utilized a questionnaire and in-depth interviews to more fully understand the experiences and needs of students with disabilities in higher education. The first phase of the study was a questionnaire administered to 504 students from which four students who disclosed disabilities were randomly chosen for interviews (Vickerman & Blundell, 2010). The weaknesses identified in this study were convenience sample of students studying only certain subjects at one university and limited discussion of methodology, which reduced the ability for others to replicate this study; while this appeared to be a phenomenology, only very little was reported with respect to student interviews. However, what was found in the questionnaires was very interesting. Twenty-five percent of students who reported a disability on the questionnaire had not disclosed it on admission due to fear of discrimination. Of those who did declare a disability, well over half were not contacted by any faculty or staff regarding possible accommodations before courses started and, of those who were contacted, only about 60% said the conversation was helpful (Vickerman

& Blundell, 2010). Eleven percent of students with disabilities reported assessments did not cater to their documented needs. One student reported the tutor stated, “It would not be fair to other students who didn’t receive these accommodations” (Vickerman & Blundell, 2010, p. 28). Lastly, 50% of students with disabilities did not receive any contact from career services and those who did found the advice limited (Vickerman & Blundell, 2010). Vickerman and Blundell stated, “The good experiences for students largely depended on the attitudes, experience, and personal knowledge of particular members of staff, rather than institutional policies and provisions” (p. 29). This was encouraging because each of us, individually, could play an important role in the success of students with disabilities. However, institutional policies addressing how we work with students with disabilities and consistent education for faculty are needed to ensure consistency in meeting the needs of this population of students.

Quinlan, Bates, and Angell (2012) conducted a qualitative study examining students with learning disabilities’ perceptions of classroom accommodations. Three kinds of accommodations were identified by these students: non-accommodation, formal accommodation, and accommodation for all (Quinlan et al., 2012). Non-accommodation referred to instructors who, in their first course meeting, indicated they were rigid followers of their syllabi with no exceptions (Quinlan et al., 2012). Even if instructors would accommodate, many students with disabilities were intimidated to disclose at this point. Formal accommodations referred to doing what was required under the law and the school’s disability policy to meet the needs of the student (Quinlan et al., 2012). While this could be a positive experience for students with a disability, it might also cause them to feel singled out and separate from the rest of the class because the

instructor was doing something different just for them. Lastly, accommodation for all referred to a classroom where all students were afforded the opportunity to learn in their own way (Quinlan et al., 2012). The methods of instruction in this classroom accommodated all learning types and needs and the instructor was open and flexible to changing the method if it was not effective. This teaching method allowed students with disabilities to feel supported and not singled out.

Reinschmeidt, Sprong, Dallas, Buono, and Upton (2013) sought to answer two research questions: “Is there a relationship between subjective well-being and onset of disability for postsecondary students with disabilities; and how satisfied are these students with the accommodations they received through Disability Support Services (DSS)” (p. 5)? Previous research had shown that early onset (at birth) disabilities led to higher feelings of well-being than later onset disabilities. The study by Reinschmeidt et al. indicated feelings of subjective well-being and onset of disability were not significantly related. In surveying student satisfaction with accommodations they received, students reported they were satisfied overall.

Interestingly, top-rated accommodations were supplied directly through DSS while bottom-rated accommodations often involved a third party and took place outside of the DSS office (Reinschmeidt et al., 2013). This was an important incidental finding that supported the need for faculty and staff to have an understanding of disability laws and accommodations. Weaknesses identified in this study were the survey was conducted only over two weeks, one of which was a school holiday, and the survey was only offered in written and online versions (Reinschmeidt et al., 2013). This potentially limited accessibility to some students with disabilities, which could affect how well the

study was representative of the population. The most impactful finding in this study was the incidental finding identifying lower student satisfaction scores with accommodations that involved a third party or were outside the DSS office. This had very important implications for future research.

Herbert et al. (2014) reported college graduation rates were 58% for students without disabilities and ranged from 21%-34% for students with disabilities. The impact of gender, race, type of disability, housing (on or off campus), campus location, financial aid resources, and grade point average (GPA) on the bachelor's degree completion rate for students with disabilities was investigated (Herbert et al., 2014). Over one-half of students initially seeking services with the Office of Disability Services (ODS) did not receive them due to poor follow-through on the student's part or ineligibility under the ADA (2014). The difference in graduation rates of these students compared to students who received services was negligible. The two significant predictors of graduation were GPA and matriculation at the same campus (Herbert et al., 2014). Having at least one university contact person (within or outside the ODS) who was actively engaged with the student made the difference in persistence to graduation (Herbert et al., 2014). This was a strong study but an identified limit was data were collected from only one university so it was not generalizable. There is still much to be understood about the many factors contributing to students with disabilities' persistence to graduation and the types, duration, and sequence of services to best accommodate these students (Herbert et al., 2014).

Hong (2015) completed a qualitative study reviewing the reflective journaling of 16 college students with disabilities over a 10-week period in one semester. While this

study was conducted at a single university, it was a well-designed study and the methodology was richly described in the text. As found in previous studies, instructors and advisors played a major role in impacting student outcomes. Many of the students reported a mental struggle with whether it was worthwhile to disclose their disability due to the unpredictability of instructors' responses and uncertainty of the effectiveness of support (Hong, 2015). This was typically due to past negative experiences with disclosing to professors. These students with disabilities also did not feel most professors were sensitive to keeping the disability confidential and often said things in front of other individuals about a student's disability or accommodations (Hong, 2015). This study also exposed the students with disabilities' lack of self-awareness and self-advocacy skills (Hong, 2015). This might be in part to the transition from secondary school, where the school was responsible to make sure accommodations were adequate, to higher education, where this responsibility fell on the individual student.

Summary

In reviewing the articles focused on postsecondary students with disabilities, many different institutions were studied along with students who had varied disabilities. Attitudinal barriers played a primary role in the experiences of students. Interestingly, two main themes emerged from these studies: the importance of a positive response from faculty or staff and the difficulty students with disabilities identified in advocating for themselves. The juxtaposition of these issues was quite obvious as they had an overwhelming impact on one another. Further education is needed for faculty and students concerning disabilities and accommodations.

Experiences of Nursing Students with Disabilities

Remarkably, little research has been conducted recently that focused on the experiences of the nursing student with a disability. Many of the articles available dated back to the 1990s and early 2000s. For example, Magilvy and Mitchell (1995) performed a nationwide descriptive study to understand the extent to which students with disabilities were admitted to schools of nursing (SON), accommodations that worked for them, specific disabilities these students had, and to learn positive strategies from these specific cases. Unfortunately, Magilvy and Mitchell found most SONs did not keep records of students with disabilities and were generally unaware of most nonvisible disabilities upon admission. In addition, while SONs indicated a willingness to accommodate students with disabilities, they had little knowledge about disability laws or accommodations. This lack of awareness was identified as one of the major obstacles facing students with disabilities (Magilvy & Mitchell, 1995). Success stories of students with disabilities were a result of collaboration and creative problem solving. Sadly, even students who were successful in SONs had difficulty passing the National Council Licensure Exam due to its limited provision of accommodations (Magilvy & Mitchell, 1995). As seen in the articles addressing postsecondary students with disabilities, nursing students with disabilities often attributed their success to faculty members who were willing to meet their needs (Magilvy & Mitchell, 1995).

In a qualitative multiple case study performed by Maheady (1999) with nursing students who had physical disabilities, six important themes emerged. First, nursing student with disabilities found support in many ways (Maheady, 1999). Family, friends, faculty, staff, and other students provided support and encouragement to aid in the

student's success in the nursing program. Secondly, attitudinal barriers such as marginalization, negative attitudes, and resentment from other students were more prevalent than physical barriers (Maheady, 1999). Despite support reported previously, attitudinal barriers still existed and had a large impact on nursing students with disabilities. It led to hesitancy in some to disclose their disabilities. While physical barriers were identified, most of these were overcome with simple accommodations and students went on to be successful in caring for patients even though they did not necessarily meet the requirements of their SON. Next was the persistence of nursing students with disabilities to persevere through pain and limitations to succeed in SONs. The fourth theme was fear due to possible consequences of disclosure (Maheady, 1999). Many students who had nonvisible disabilities did not disclose until after they were admitted into the program. Others applied to hundreds of SONs until they found one willing to accommodate their disability. Then, nursing students with disabilities often had excellent rapport with patients due to their ability to understand patients' situations in a way able-bodied nursing students could not (Maheady, 1999). Finally, nursing students with disabilities found more similarities than differences with other students who did not have a disability. It was also apparent from the study that some unique clinical safety issues might arise with students with disabilities: "Some of the students missed call lights, monitor alerts, and adventitious breath sounds due to a hearing impairment, one became dizzy and confused due to hypoglycemia" (Maheady, 1999, p. 169). These reportedly created concern about the student's ability to become a competent practicing nurse.

In her 2000 article, Marks “calls to the carpet” Maheady (1999) for her use of the medical model as the framework for her article (summarized above), suggesting the entire situation changes when viewed through the lens of the social model of disability. She quoted Maheady as saying, “Fortunately, the limitations of the participants did not result in any known harm to the patients they cared for, but the potential threats to patients’ health and safety must be emphasized” (Marks, 2000, p. 205-206). Marks responded that this statement was discriminatory toward students with disabilities because in reality, safety is a concern for ALL nursing students, not only students with disabilities. According to Marks, language used throughout Maheady’s article only served to further isolate nursing students with disabilities and further perpetuate negative stereotypes. Further, the statements of many of the nursing students with disabilities in Maheady’s article indicated abuse and cruelty such as discrimination and bullying at the hands of peers, faculty, and clinical facilities that should not be tolerated as normal activity and should be reported (Marks, 2000). Marks continued by asking if patients would prefer peers and staff, who were so cruel and discriminatory in Maheady’s study, to care for them over a nursing student with a disability. To view Maheady’s study from the social model of disability framework as Marks did definitely changed the interpretation. It illustrated the importance of nurses, faculty, and researchers having an adequate knowledge of disability culture to improve the experiences of nursing students with disabilities (Marks, 2000).

In another article by Marks (2007), the important role of nursing students with disabilities in leading the change to more culturally competent care was discussed. Because of the reliance on the medical model, Marks identified that nurse educators

might be guilty of perpetuating historical attitudes and actions that inhibit admission and disclosure of nursing students with disabilities. Students with disabilities reported attitudinal barriers as one of the greatest barriers they faced and people's reactions to them were more difficult to cope with than the disability itself. Marks reported that disability is now a widely accepted cultural minority and should be treated as such. It is likely "nursing students with disabilities will foster a new set of knowledge, skills, and attitudes in the nursing profession which will improve nursing care and advance culturally relevant care" with their unique perspective (Marks, 2007, p. 73).

Dailey (2010) completed a phenomenological study of the lived experiences of nursing students with chronic illnesses. While her sample was acquired from one university and was homogenous, it reflected four themes identified in other studies of experiences of students with disabilities. The first, needing to be normal, described participants' desire to find ways to fit in and not draw attention because of the disability (Dailey, 2010). Due to this desire, students learned to push through pain, fatigue, and other troubling side effects to maintain an appearance of normalcy, sometimes to the detriment of their own health and wellness (Dailey, 2010). The second theme dealt with the behavior of others. Students with disabilities already have a heightened sense of their otherness and the behaviors of others might sometimes perpetuate those feelings, even unintentionally. One student reported, "I have just learned to be more sensitive to their ignorance" (Dailey, 2010, p. 9). The participants taught others about their chronic illness and worked to build rapport with their instructors to create positive encounters. The third theme was enduring the restrictions of illness (Dailey, 2010). All participants talked about fatigue as one of the most overwhelming symptoms they had to deal with

throughout the nursing program. This impacted all aspects of their participation in nursing school--from classroom participation to clinical experiences. The last theme identified was learning from self to care for others (Dailey, 2010). One participant stated,

Chronic illness has enhanced my nursing. As I've said to my instructors, "I've been there. I know what it's like to be the patient." That's probably where my strong points are as a nursing student...caring. I know how it is to be in that bed because I've been there many times. I would say at least 17 of my 22 years I have been in that bed at least once a year. (Dailey, 2010, p. 14)

The inner strength developed from living with a chronic illness, along with compassion and sympathy for patients, is valuable for practice as a caring nurse.

Neal-Boylan and Miller (2017) took a slightly different approach using a retrospective qualitative study to describe the experiences of nurses who had disabilities while in school. The sample consisted of 15 nurses from eight states; all were licensed registered nurses who had been in nursing since 1990 (to account for initial ADA legislation; Neal-Boylan & Miller, 2017, p. 177). Common themes that emerged from the study included wanting "to be treated like everyone else," inadequate accommodations or being denied accommodations from the school of nursing, faculty concern about safe care, and the impression the student with a disability could never be a nurse (Neal-Boylan & Miller, 2017). Also noted was peer and disability office support were most helpful and having a disability made them more empathetic nurses (Neal-Boylan & Miller, 2017). Limitations identified in this study were the qualitative nature and small sample size as well as the fact that most of the participants had learning disabilities and only a few had physical disabilities (Neal-Boylan & Miller, 2017).

Summary

Investigations regarding the perspectives of nursing students with disabilities were very limited. Studies that were conducted indicated it was important that the nursing profession transition to viewing nursing students with disabilities under the light of a more inclusive model of disability versus strictly adhering to the medical model. As seen in the studies of non-nursing students with disabilities, nursing students with disabilities also avoided disclosure due to fear of discrimination. They also similarly suffered from the lack of faculty awareness of disability laws and accommodations and reported attitudinal barriers as one of the greatest barriers they faced. Some studies addressed safety issues surrounding students with disabilities in clinical settings but as noted, these were actually no different than the safety issues posed by any nursing student in a clinical setting. Nursing faculty might be most fascinated by the inner strength and compassion exhibited by the students with disabilities, which increased rapport with patients. Compassion and empathy are some of the most important and difficult concepts to teach in nursing.

Nurses with Disabilities in the Clinical Setting

In 2007, Sin and Fong published an article discussing the discrimination of individuals with disabilities in caring professions due to the inconsistent implementation of regulatory fitness requirements in the United Kingdom. They argued these fitness requirements, similar to the United States' essential functions, either deterred individuals with disabilities from entering caring professions or created an atmosphere of nondisclosure that could prevent the person from getting the accommodations they needed to do their job safely and effectively (Sin & Fong, 2007). In addition, the case

was made that using fitness requirements as a “risk-management strategy” was ineffective as it might cause individuals with disabilities, especially nonvisible disabilities, to hide them and actually create more of a risk due to nondisclosure (Sin & Fong, 2007, p. 47).

The quantitative exploratory study performed by Kontosh, Fletcher, Frain, and Winland-Brown (2007) explored hiring practices and attitudes toward working with nurses with disabilities in the clinical setting. While this study was limited to one county in a southeast state and the nurses and hiring administrators who worked there, the findings reflected what had been found in other studies. Initially, they identified that “workplace attitudes” continued to be a barrier to nurses finding work with disabilities (Kontosh et al., 2007, p. 300). They also found both hiring managers and nurses’ attitudes toward nurses with disabilities were more accepting if they had previously hired or worked with a nurse with a disability; for nurses, the attitude was specific to the disability they had been exposed to in the past (Kontosh et al., 2007). In other words, exposure to someone with a physical motor disability did not improve attitudes toward someone with a psychological disability.

In 2008, Neal-Boylan and Guillett interviewed nurses with physical disabilities and nurse recruiters in three eastern states and across many clinical settings. They sought to understand the experiences of nurses with disabilities in the workplace and if changing the educational system could make a difference. Themes identified from this exploratory descriptive qualitative study were “fatigue, reduced stamina, and pain; patient safety; nursing heroics; lack of awareness/knowledge and stigma; hidden disability; and creativeness of the individual (Neal-Boylan & Guillett, 2008, pp. 164-165). These were

largely identified as barriers to being able to work with a disability and the primary facilitator for nurses with disabilities was a “supportive colleague” (Neal-Boylan & Guillett, 2008, p. 166). Many modifications were suggested for the workplace from physical changes to attitudinal changes but the prevailing theme was to “promote awareness and education and focus on abilities” (Neal-Boylan & Guillett, 2008, p. 166). The recommendation for educational partners was to consider multiple educational tracks in nursing (Neal-Boylan & Guillett, 2008). This would allow students with disabilities to choose a nursing track and tailor clinical experiences to meet their needs and the requirements of the specific degree track (Neal-Boylan & Guillett, 2008). Ideally, it would also produce nurses who are not only physically competent but, more importantly, intellectually able to fill needed roles in the nursing profession.

To understand the experiences of nurses with disabilities working in the hospital setting and to identify the factors comprising a disability climate, Matt (2008) undertook a grounded theory study. The sample consisted of 11 nurses with self-disclosed physical or sensory disabilities living in a single U.S. state. From in-depth interviews with the participants, Matt developed the nurse first model, which refers to the nurse’s desire to be seen as a nurse first and an individual with a disability second. This model consisted of four domains that captured the desires and actions of these nurses: “dealing with the environment, gaining acceptance by peers, gaining support from supervisor, interacting with patients” (Matt, 2008, pp. 1528-1532). Again, support and acceptance from supervisors and peers played a significant role in the success of nurses with disabilities and the suggestion was made for “disability awareness training” for those supervisors and peers (Matt, 2008, p. 1534).

In 2010, Wood and Marshall conducted a study of nurse leaders' attitudes, concerns, and experiences in hiring and working with nurses with disabilities. This nationwide study targeted about 10% of the nation's hospitals. Interestingly, this study did not limit for specific disabilities and 31% of reported disabilities were recovering addictions (Wood & Marshall, 2010). The study found "70% of nurse managers rated the job performance of nurses with disabilities under their employ as exceptional or above average" (Wood & Marshall, 2010, p. 185). Not surprisingly, Wood and Marshall also found previous experience working with an individual with a disability significantly contributed to a positive attitude.

Neal-Boylan et al. (2011) explored the perceptions and characteristics of RNs with sensory disabilities and their risk of job retention problems in a quantitative descriptive pilot study. The sample consisted of 80 nurses from 21 states representing all regions of the United States (Neal-Boylan et al., 2011). They found nurses with more severe impairments were not currently working as nurses. Also, nurses with graduate degrees were more likely to have difficulty hearing as opposed to those with bachelor's degrees (Neal-Boylan et al., 2011). In previous research, this was found to be due to individuals with disabilities seeking higher education to transition away from direct patient care and remain in nursing. Nurses with disabilities in the hospital setting were "three times more likely to be at risk for retention problems" than those in a non-hospital setting due to the perceived effect of the disability on patient care (Neal-Boylan et al., 2011, p. 29). Suggestions from this study included modifying the clinical work environment, including interventions to accommodate nurses with disabilities to support

their retention, and to use rehabilitation nurses to educate employers and change attitudes in the clinical settings (Neal-Boylan et al., 2011).

A pilot study of the Nurses' Attitudes Toward Nurses with Disabilities Scale was conducted by Matt in 2011. The convenience sample consisted of 131 RNs from three large hospitals in the northeast United States. Several limitations included the instrument was found to have flaws in some of the wording and response options but the tool accomplished the task of assessing the climate of disability within the organization and nurses' attitudes toward disability (Matt, 2011). The results indicated the nurses' experience with disability and degree of closeness to it led to more positive attitudes toward nurses with disabilities than those who had no previous exposure to individuals with disabilities. It was also found that age, level of education, and years of nursing experience did not cause significant differences in nurses' attitudes toward nurses with disabilities (Matt, 2011). Lastly, the climate of lower acuity units positively impacted nurses' attitudes toward nurses with disabilities and the perception of their ability to perform the job while higher acuity units (intensive care unit, emergency room, etc.) showed more negative attitudes among nurses (Matt, 2011).

In a study by Neal-Boylan (2012), work-life experiences of nurses and doctors with permanent physical and/or sensory disabilities were explored. The sample consisted of 10 RNs and 10 physicians with self-identified disabilities. It was found this population was more likely to leave, modify, and change the idea of their ideal job due to the disability and others were likely to overestimate the impact of the disability on job performance (Neal-Boylan, 2012). Many did not request workplace accommodations and took personal responsibility for patient safety. Once again, the study indicated both

professions could benefit from increased knowledge regarding disability law and accommodating disabilities (Neal-Boylan, 2012).

Neal-Boylan conducted an exploratory qualitative study in 2014 to consider if job descriptions provided to nurses with disabilities and the actual work required in the job were congruent. The sample was a purposive convenience sample of 17 RNs in the northeast having a permanent physical or sensory disability. The results revealed persistent themes from previous research: nurses tended to hide their disabilities as long as possible, they returned to school for less physically-demanding jobs, and they compensated for what they could no longer do (Neal-Boylan, 2014). New themes that emerged from this study were “seeking a job they can do, knowing their own limitations, having a supervisor who is empathetic or not a nurse, and issues with getting accommodations” (Neal-Boylan, 2014, pp. 173-174). Many participants reported either never seeing a job description or having a generic job description that did not match the actual work of the job; it was suggested that future job descriptions actually match the work of the job.

In 2015, Neal-Boylan and Miller completed a legal case analysis of 56 cases involving nurses with congenital or acquired physical or sensory disabilities since the inception of the ADA. Of the claims researched, 47 claimed discrimination, 26 claimed failure to accommodate, seven claimed retaliation, four claimed hostile work environment, and two claimed employer-known association to a person with a disability (such as a spouse or child; Neal-Boylan & Miller, 2015). This case law analysis indicated nurses with disabilities faced discrimination in the workplace (Neal-Boylan & Miller, 2015). Few nurses won cases brought under the original ADA of 1990 due to its

less inclusive verbiage and interpretation. The researchers discussed the fact that these same cases if brought under the ADAAA of 2008 would more likely be successful due to the broadened definition of disability and the focus on inclusivity (Neal-Boylan & Miller, 2015). The conclusion was regardless of outcome, legal action could be effective in reducing discrimination by serving as a deterrent.

Summary

Consistent with other research findings, education and exposure to others with disabilities greatly impacted employers' and peers' attitudes toward nurses with disabilities. Similar to experiences of students, nondisclosure due to fear of discrimination was prevalent in the workforce as well. Modification of work environments might benefit all nurses and keep nurses with disabilities employed as would thoughtful and accurate job descriptions. In addition, while legal action could be a deterrent to discrimination in the workplace, education and not overemphasizing an individual's disability and allowing people to be a nurse first might have the greatest impact on equality.

Nursing Students with Disabilities in the Clinical Setting

United Kingdom researchers Wright and Eathorne (2003) utilized a workshop format to explore issues and enhance knowledge in educating nursing students with disabilities, specifically in clinical practice. It is important to meet the needs of students with disabilities in academic and clinical courses. To support nursing students with disabilities in the clinical setting, staff attitudes must be addressed and the focus shifted from what the student cannot do to the strengths of the student (Wright & Eathorne, 2003). Faculty participating in the workshops reported strong, working partnerships

between SONs and clinical facilities could help change perceptions of nursing students with disabilities (Wright & Eathorne, 2003). They agreed these students must be given the opportunity to succeed by being able to practice free from discrimination.

Participants also determined that accommodating students with disabilities could promote a positive and diverse image of the nursing profession and decrease the impact of discrimination (Wright & Eathorne, 2003). Nursing faculty could model to other healthcare professionals in the clinical environment the importance of listening to the student with a disability about needed accommodations and developing a working rapport to promote student success (Wright & Eathorne, 2003). This article suggested nursing faculty recognize the impact of attitudinal barriers faced in the clinical setting by students with disabilities and look for ways to promote student success.

An article by Australian researchers Andre and Manson (2004) considered the needs of students with disabilities in clinical experiences and what instructors could do to ease the transition from classroom to clinical experiences. They pointed out the attitudes of most healthcare professionals regarding disability were informed by the medical model, which might cause them to view a student with a disability as incapable of performing successfully in clinical. As a clinical instructor aiding a student in the transition to clinical practice, it is important to highlight the student's capacity instead of his/her incapacity (Andre & Manson, 2004). The article discussed several practical applications faculty could use to assist students with disabilities in preparation for clinical: visiting the clinical facility with the student prior to clinical to determine any barriers and consider possible accommodations; discuss clinical requirements and accommodations openly with students; with students' permission, inform clinical

facilities about the need for accommodations and elicit their help in accommodating the student; and serve as an advocate for the student in clinical (Andre & Manson, 2004). Practical applications discussed in this article could be useful in accommodating students with disabilities in clinical settings.

Morris and Turnbull (2006) conducted an exploratory qualitative study in the United Kingdom to explore the clinical experiences of nursing students with dyslexia and the potential influence of this disability on their practice. They identified five themes. The first was disclosure. Most students reported being uncomfortable with disclosing their disability in the clinical setting. They considered the “clinical culture potentially discriminatory” (Morris & Turnbull, 2006, p. 241). The second theme identified was self-managing strategies. Nursing students with disabilities utilized several independent strategies to manage clinical practice in light of the diagnosis of dyslexia: using a voice recorder or note pad to recall needed information, avoidance, and regular practice of clinical skills in a non-threatening environment. While avoiding particular situations was not recommended, the other strategies might be very beneficial. Most students recognized the potential for unsafe practice so were hyper vigilant, especially in medication administration. These students would check medications multiple times, have faculty or nurses recheck, and use drug calculation tools (Morris & Turnbull, 2006). The third theme was the need for more time. All students included in the study reported patient safety as a number one priority. This focus on safety required more time for some students with disabilities and might also require a quiet environment with limited distractions at times (Morris & Turnbull, 2006). The next theme was the emotional aspect of being a nursing student with dyslexia. All emotions reported by students

related to their diagnosis of dyslexia were negative. Most were directly attributable to the attitudes of others. Students stated that colleagues only referred to the weaknesses associated with their disability and they often felt “different” (Morris & Turnbull, 2006). The last theme identified was the choice of future work setting. All students had considered viable work options to account for their disabilities. Some preferred a faster pace due to their short-term memory issue while others felt a slower pace would better accommodate the time they needed to feel confident in safe practice (Morris & Turnbull, 2006). Although this study was focused on nursing students with dyslexia, its themes might be generalized to many other disabilities. It is important to understand the perspectives of students with disabilities so they can be adequately supported throughout their nursing programs and into their professional careers.

United Kingdom researchers Sanderson-Mann and McCandless (2006) sought to understand dyslexia and nurse education in the clinical setting. Using previous research, they identified several areas that impacted students with dyslexia’s success in clinical placement. The positive aspects of dyslexia are not often considered. Most individuals who have dyslexia are multidimensional thinkers who are very insightful and highly aware of their environments. They are also creative problem solvers and are typically kinesthetic learners, which pairs well with nursing (Sanderson-Mann & McCandless, 2006). Although these positive aspects are often overlooked or downplayed, they can be very beneficial to the nursing profession. Unfortunately, most nursing professionals are more aware of the difficulties associated with dyslexia including communication issues, time management problems, inconsistent performance in classroom versus clinical, and difficulties with paperwork (Sanderson-Mann & McCandless, 2006). Healthcare

professionals and institutions often only recognize the negative aspects and associate disability with unsafe practice (Sanderson-Mann & McCandless, 2006). Nurse educators need to create supportive clinical atmospheres that will reduce anxiety for students with dyslexia and promote positive attitudes in healthcare professionals (Sanderson-Mann & McCandless, 2006). While stress has been found to negatively impact the performance of students with dyslexia, practice tends to improve performance (Sanderson-Mann & McCandless, 2006). Practice might take extra time but it results in confident nursing students with dyslexia.

Clinical faculty and mentors need to understand the importance of attitudinal barriers for nursing students with disabilities (Sanderson-Mann & McCandless, 2006). Several strategies were discussed that could promote success in nursing students with disabilities in the clinical setting: review objectives frequently, conduct frequent informal evaluations of performance, check clinical skills, chart on scrap paper before inputting into permanent record, and positive feedback (Sanderson-Mann & McCandless, 2006). With the above interventions, nurse educators could allay fear and provide nursing students with disabilities a supportive environment in which to learn and practice.

Tee et al. (2010) performed an evaluative case study to determine the impact of student practice learning advisors (SPLAs) on support for students with disabilities in the United Kingdom. Student practice learning advisors were responsible for supporting students with disabilities and coordinating services between all needed resources. While these positions are not available in all institutions of higher education, the study indicated the need for students with disabilities to have an advocate. This study found students with disabilities required about 20% more time involvement from faculty and other

resources to be successful than did their non-disabled counterparts (Tee et al., 2010). Most universities in the United Kingdom have established systems in place to provide this support to students in classroom activities but clinical settings might not be as supportive. Advocacy provided by the SPLA increased communication between schools of nursing and clinical facilities (Tee et al., 2010). As seen in many previous studies, the importance of an advocate who took time to support students with disabilities was vital to their success.

In the United Kingdom, a model was developed as a supportive framework for nursing students with disabilities by Griffiths, Worth, Scullard, and Gilbert (2010). This “six phase tripartite model” was designed to ensure support before, during, and after clinical placement; it consisted of the following cyclical steps:

disclosure (identifying and assessing needs), establishing support systems and processes in practice; mid-placement review (determine alternative strategies), development of detailed plans and models of support (establish a critical information base), end of placement review (evaluation), and revision of the support strategy. (Griffiths et al., 2010, p. 135)

Griffiths et al. (2010) described a case study of the model in action. One recommendation was to have disability service providers spend a day in different practice settings to more fully understand the complexities of these environments and be better able to suggest accommodations for nursing students with disabilities (Griffiths et al., 2010). Students who disclose disabilities take a great risk of being stigmatized at each disclosure and nursing students with disabilities must face the challenge of disclosure multiple times throughout their program. Faculty and clinical staff need to be educated and supported in their efforts to accommodate nursing students with disabilities in both classroom and clinical settings and this model provided a consistent way to ensure this

was completed (Griffiths et al., 2010). Collaboration between all parties involved would be the best method to fully support the student. As quoted in Griffiths et al., “The overarching tenet is that disabled students are enabled, as far as possible, to achieve their full potential in the practice setting, through a collaborative partnership” (p. 137).

Howlin, Halligan, and O’Toole (2014) discussed the development and implementation of a clinical needs assessment (CNA) for nursing students with disabilities in Ireland. This CNA was developed through a multi-phase process that involved a thorough review of literature, a review of competence standards, and consultation with expert groups (Howlin et al., 2014). The CNA includes four parts: (a) explanation of the development of the tool and overview of competencies included for faculty and clinical staff; (b) a questionnaire regarding a detailed history of the student’s disability and its impact on his/her life (this information is kept confidential); (c) identification of factors that might aggravate the disability, a list of reasonable accommodations outlining the responsibilities of all parties involved, and a place for the student to provide written consent or dissent to release information from part three; and (d) an evaluation of the effectiveness of accommodations (Howlin et al., 2014). The CNA was found to support disclosure by providing a safe environment for students with disabilities to discuss concerns and make decisions regarding disclosure (Howlin et al., 2014). As in previous studies, collaboration, communication, and education were vital to the successful support of students with disabilities and the CNA helped facilitate each of these components (Howlin et al., 2014). The authors recognized the use of the social model of disability to develop the CNA shifted the focus away from the disability and toward the “demands of nursing” and “the impact of the environment on the ability of the

student to learn and perform patient care” (Howlin et al., 2014, p. 562). This tool helped to create an atmosphere of inclusivity rather than exclusivity when considering clinical placement for nursing students with disabilities.

A phenomenological study of the lived experience of nursing students with disabilities in the clinical setting was conducted by Luckowski (2014). This was a much-needed study in the United States as almost all previous research on clinical experiences of nursing students with disabilities had been conducted in other countries. Five primary themes were identified; these themes corroborated previous research as well as added to the body of knowledge on this topic with new findings. The first theme, Masking a Disability, supported previous findings that mistrust and fear of discrimination led many students to avoid disclosing a disability (Luckowski, 2014). Theme two, Revealing a Disability, indicated some students openly disclosed their disability while others did not disclose until situations arose where they could no longer hide it (Luckowski, 2014). It was noted that gaining the trust of the student was an important factor in his/her comfort with disclosure (Luckowski, 2014). Theme three was Affecting Clinical Experiences. Many nursing students with disabilities identified feelings of disappointment at being unable to participate in some clinical experiences, difficulty with clinical/skill testing, an undercurrent of discrimination in clinical facilities, and choosing a work specialty based on its fit with the disability (Luckowski, 2014). Overcoming Challenges in Clinical was theme four and students reported the need for self-motivation and perseverance. They also conveyed the importance of feeling supported and discussed strategies they had developed to succeed (Luckowski, 2014). Lastly, Sharing Experiences with Others was identified as a theme. Being able to share their personal disability experiences with

patients, fellow students, clinical instructors, and faculty allowed nursing students with disabilities to connect on a personal level and educate along the way (Luckowski, 2014).

Symes (2014) conducted a quantitative study to determine what clinical accommodations pre-licensure schools were providing for nursing students with disabilities, nursing education administration's perceptions of the effectiveness of those accommodations, and nursing education administration's perceived barriers in providing clinical accommodations (Symes, 2014). While this study was conducted nationwide within the United States, its low response rate and limitation to only nursing education administrators were identified weaknesses. The study documented many clinical accommodations made in the categories of skill performance, clinical placement, and patient assignment; special equipment usage; service animals; altered clinical schedules; cognitive/learning strategies; other accommodations; and common support strategies (Symes, 2014). The most frequently used accommodations were support strategies centered on referral of students for various services followed by support of students in disclosing issues that affected clinical learning (Symes, 2014). These support strategies were found to be perceived as most effective by nursing education administration (Symes, 2014). The strongest barrier to providing clinical accommodations for nursing students with disabilities was the clinical facilities' concern for patient safety.

An Australian qualitative exploratory study undertaken by Rankin et al. (2010) sought to understand healthcare organizations' perspectives of clinical placement for nursing students with disabilities. Seven themes were identified in the study but only three were discussed in this article along with recommendations for successful clinical placement. The first theme was Workplace and University: Bridging the Reality Gap by

Joint Commitment. It was noted that students might not realize the physical and mental demands of the profession of nursing until they began clinical practice. This could create difficulties in accommodating students with disabilities. Healthcare organization representatives expressed their desire to accommodate students with disabilities but added they reserved the right to refuse clinical placement if they felt it was beyond the student's ability or would create undue hardship for the staff (Rankin et al., 2010). The second theme, Disclosure and Confidentiality, was a conundrum. While healthcare organizations understood the students' right to confidentiality, they felt disclosure was essential and ethical with respect to clinical placement. Nondisclosure might affect student, staff, and patient safety. Overwhelmingly, healthcare organization representatives reiterated the importance of disclosure in the context of clinical placement. In addition, they emphasized they would make every effort to accommodate any student who disclosed a disability (Rankin et al., 2010). The third theme was Proactivity Through Commitment, Collaboration, and Communication. Each student, each nurse, each unit, each clinical site, and each university might be different. It was imperative to foster a focus on the student's strengths rather than his/her disabilities to make room for additional opportunities. Since each case might be so different, commitment, from all parties involved, to collaboration and communication was a necessity for student success (Rankin et al., 2010). Finally, the authors made the following recommendations for successful clinical placement of nursing students with disabilities: (a) assist potential students to determine if nursing was the right field for them, (b) actively engage the student to develop strategies for successful clinical placement, and (c) develop collaborative policies for meeting the needs of nursing

students with disabilities (Rankin et al., 2010). Remarkably, this was the only study found that addressed the perspectives of clinical facilities.

Summary

Very little research has been done on the topic of nursing students with disabilities in the clinical setting, especially in the United States. Regrettably, the clinical setting is where many of the issues faced by students with disabilities arise. The literature indicated attitudinal barriers perceived by nursing students with disabilities were due largely to the pervasive influence of the medical model approach to these students. A shift in focus to the unique strengths of this population of nursing students, instead of the disability, is needed. As in the classroom, disclosure and nondisclosure are major elements in educating nursing students with disabilities in the clinical setting. Feelings of trust and support in the student would help improve this issue. In fact, feeling supported was one of the primary needs of students with disabilities in the clinical setting. Individuals most influential in helping nursing students with disabilities to feel supported are faculty members in these clinical settings. A significant point to consider in educating these students clinically is the perception of the clinical facilities in allowing students with disabilities to practice. To date, no studies within the United States have sought to understand the attitudes of acute care nurses who work with students in the clinical setting concerning students with disabilities.

Conclusion

Throughout the literature, two primary themes related to students with disabilities continuously emerged: difficulty of disclosing a disability and the need for a positive response and support. Nurses, nursing students, and non-nursing students with

disabilities all struggle to overcome the fear of disclosure due to discrimination and marginalization. This is precipitated in nursing by the seeming ubiquity of the medical model of disability that identifies disability as something in the individual that needs to be “fixed.” Education and training have proven to be effective methods in improving perceptions of nurses and students with disabilities. When individuals with disabilities trust and feel supported by those around them, they are more likely to disclose their disabilities and advocate for needed accommodations. In clinical settings, however, healthcare professionals’ concern for patient safety heightens the concern about practicing nurses and students with disabilities. While research has been conducted regarding nurses with disabilities in the clinical setting, no research has been conducted within the United States with regard to attitudes of acute care nurse in having nursing students with disabilities practice and learn in their clinical settings. As partners in educating nurses, it is important to understand these attitudes so the nursing student with a disability is provided the best chance for success.

With the current impetus in nursing on cultural diversity and a return to its roots within social advocacy, nursing stands in a place to promote equality for individuals with disabilities (Scullion, 2010). Scullion (2010) stated that “greater inclusion of disabled people as nurses would challenge discrimination and improve healthcare for disabled people” (p. 702). For individuals with disabilities to become nurses, they must be able to be successful in schools of nursing. To accomplish this, it is important to understand the culture of acute care nursing and related attitudes toward nursing students with disabilities. These attitudes are beliefs, feelings, and behavioral intentions, which might be culturally impacted and could create barriers for nursing students with disabilities.

Using focused ethnography to examine this specific problem within the culture of acute care nursing would help to understand the issue and provide a guide for social change within the acute care nursing environment.

CHAPTER III

METHODS

Introduction

This study sought to understand acute care nurses' attitudes toward nursing students with disabilities. Limited research was available regarding this topic and what was conducted primarily focused on faculty and the students themselves. A gap lies in understanding acute care nurses' attitudes toward nursing students with disabilities as clinical practice is a principle component of success in nursing. The social model of disability guided the research by addressing pervasive attitudes surrounding students with disabilities.

Restatement of the Research Question

Given the scarcity of literature regarding nursing students with disabilities, this issue needed to be explored. A focus on acute care nurses addressed the most understudied factor affecting this population. Therefore, the following research question and sub questions were answered with this study:

- Q1 What are acute care nurses' attitudes toward nursing students with disabilities?
 - Q1a What beliefs do acute care nurses hold about nursing students with disabilities?
 - Q1b What feelings do acute care nurses have about nursing students with disabilities?

Q1c What behavioral intentions do acute care nurses have for working with nursing students with disabilities?

Participant Selection

Participants for this study were nurses actively involved in the acute care clinical experiences of nursing students and had at least two years' experience precepting students. Participants were not limited by type of unit, licensure or education level, or years of experience to allow for a more complete understanding of the culture of acute care nursing and its effect on the attitudes of nurses toward students with disabilities.

Entry into the field began with a purposive sample of nurses who are 2015 or earlier graduates from area schools of nursing. The participant group was expanded through the snowball method by asking the initial participants to make referrals to other nurses who might meet the criteria. These additional participants were provided information on the study and the researcher's contact information so they could choose whether they wished to participate. Fetterman (2010) emphasized that an introduction by a member of the community who has some credibility within the culture might open doors for the researcher. Use of nurses from various facilities allowed for differing perspectives and covered the breadth of the acute care experience to which students were exposed. Inclusion criteria were based on licensure as a nurse, at least two years' experience precepting students, and potential ability to provide detailed descriptions when interviewed.

Methods Selection and Research Design

Qualitative research is sometimes used when issues need to be explored and little or no previous research is available on the topic (Merriam, 2009) as was the case for understanding acute care nurses' attitudes toward nursing students with disabilities.

Having the researcher as the key instrument is also a benefit of qualitative research (Creswell, 2013; Merriam, 2009). The ability to adapt on the fly during interviews, clarify communication, and receive participant feedback allows the researcher to consider all angles and points of view and build an understanding of the phenomenon. Using an inductive process and reflexivity leads the researcher to move from the concrete information obtained to the broad themes that identify the issue. At the same time, “positioning themselves” within the study allows the researcher to critically evaluate biases and the impact he/she might have on the study (Creswell, 2013, p. 47; see Appendix A). Since so little was known about acute care nurses’ attitudes toward nursing students with disabilities, it was critical to utilize an emergent design. This allowed the researcher to follow the evidence and modify the processes and plan as needed to provide a thorough and holistic account of the phenomenon (Creswell, 2013).

Ethnography, one of the oldest qualitative research methods, began in cultural anthropology when researchers sought to understand primitive and previously unknown cultures (Creswell, 2013; Cruz & Higginbottom, 2013; Higginbottom, Pillay, & Boadu, 2013; Oliffe, 2005; Robinson, 2013; Wall, 2015). Over time, it was realized ethnography could be used to understand, describe, and effect change in multiple subcultures and groups not defined by ethnicity or geography (Cruz & Higginbottom, 2013; Wall, 2015).

One method that emerged from ethnography, one particularly useful in healthcare research, was the focused ethnography. In focused ethnography, the researcher focuses on a specific problem or context within a specified group (Butcon & Chan, 2017; Cruz & Higginbottom, 2013; Higginbottom et al., 2013; Knoblauch, 2005; McElroy et al., 2011; Oliffe, 2005; Pink & Morgan, 2013; Rashid, Caine, & Goetz, 2015; Robinson, 2013;

Wall, 2015). This is especially important in today's highly differentiated societies and among healthcare workers who are segregated by many factors (Butcon & Chan, 2017). Focused ethnography has been used primarily in disciplines like nursing that are practice-based to give insight into specific cultural perspectives and provide a direction for practice (Butcon & Chan, 2017; Cruz & Higginbottom, 2013; Wall, 2015). Knoblauch (2005) gave the example of focused ethnography as focused on an "aspect of a field" rather than the entire culture: "rather than police as a field, the focus is on the question as to how police officers do their rounds" (para. 21). In the context of this study, rather than nursing as a field, the focus was on acute care nurses' attitudes toward students with disabilities. To achieve this level of focus, the researcher must have previous knowledge and understanding of the field to be studied (Butcon & Chan, 2017; Knoblauch, 2005; Wall, 2015). This researcher's experience as an acute care nurse and a nurse educator placed her in a position of understanding the role and responsibilities of the clinical nurse and also an understanding of the student's perspective. To address the question of acute care nurses' attitudes toward nursing students with disabilities, "a nuanced understanding of the subculture will allow for comparison and explanation of their uniquely situated conditions and is paramount to meeting the needs and protecting the interests" of nurses and nursing students with disabilities alike (Butcon & Chan, 2017, p. 7).

Furthermore, the social model of disability identified disability as a product of the culture, society, and the environment. Because culture, society, and the environment are also significant factors in attitude formation (Schwarz, 2007), it was important to evaluate the specific problem of acute care nurses' attitudes in relation to the specific environment and culture of acute care nursing. Focused ethnography was designed to study these

specifics and guided the researcher in understanding this phenomenon with regard to the culture and environment.

Using a focused ethnography approach, the researcher conducted interviews with acute care nurses who had at least two years of experience precepting students. The interview protocol incorporated questions to elicit responses concerning attitudes regarding disability: how the attitudes were formed, how they were impacted by the culture of acute care nursing, and what significance they had for behavior. The interview protocol was piloted with nursing faculty to improve the interview questions and ensure the research questions were answered by the questions in the protocol. Hypothetical scenario questions were used as part of the protocol to determine the significance of the attitudes for behavior. Higginbottom et al. (2013) suggested the use of scenarios or vignettes to replace participant observations when researching sensitive topics.

Data Collection Procedure

Data were collected using Creswell's (2013) data collection circle that included "locating site/individual, gaining access and making rapport, purposefully sampling, collecting data, recording information, resolving field issues, and storing data" (p. 146). Accessing the population began with approval from the University of Northern Colorado Institutional Review Board (see Appendix B). Purposeful and opportunistic sampling was achieved through solicitation and referral. Nurses who graduated from two local schools of nursing in 2015 or earlier were invited to participate in the study and asked to share the researcher's contact information with other nurses who might be interested in participation. The sample size was planned as large as needed to richly and fully describe the attitudes of this specific cultural group toward nursing students with disabilities.

Therefore, recruitment continued until data saturation was achieved. The final sample size was 20 participants.

A letter of invitation for participation was sent via email (see Appendix C). Interested participants were asked to contact the researcher. The researcher screened for eligibility and a date, time, and location for the interview were scheduled with eligible participants. Any respondent with less than two years' experience precepting students in the acute care setting was excluded from the study. At the interview meeting, the purpose of the study was explained, questions were answered, and written consent was obtained (see Appendix D).

After consents were signed, demographic information was obtained from participants (see Appendix E). This demographic information included gender, age, location of hospital, unit, years as a nurse, years as a preceptor, level of education, and relationship with anyone who has a disability. All included participants could opt to be entered into a random drawing for a \$50 Amazon gift card.

Data were collected through semi-structured interviews using the piloted interview protocol to ensure that a deep understanding of the culture that affect acute care nurses' attitudes toward nursing students with disabilities was obtained. Having a protocol for interviewing helped the researcher stay organized and provided a place to take notes during the interview (Creswell, 2013; (see Appendix F). Use of a semi-structured format allowed participants to explore their own thoughts and feelings and direct the interview session while providing a method to keep the interview focused on the topic of interest. Initial interviews took approximately half an hour and were conducted face-to-face or via phone-conferencing. Permission was sought to contact

informants to participate in follow-up interviews to verify data if necessary. The interviews were audio-recorded on a digital recording device and field notes were taken throughout all phases of the research. Reflexive journaling immediately after interview sessions was used to bracket the researcher's personal biases and beliefs to minimize their interference with data collection and analysis.

Interview recordings were transcribed verbatim and stored on a facial-recognition protected laptop with a back-up e-copy stored on an external hard drive in a locked filing cabinet in a locked office. Hard copies of field notes, protocols, demographic data, and consents are stored in the locked filing cabinet. Participant names and any other identifying information were redacted from the transcribed data to protect anonymity. Consents will be stored in a separate locked cabinet from demographic forms, field notes, journals, and transcriptions. A master list of types of information gathered and a data collection matrix were used to maintain organization of the data.

Data Analysis Procedure

As stated by Merriam (2009), data analysis is the “process of making meaning” (p.176). This complex process requires the researcher to thoroughly analyze all types of data moving between the concrete and conceptual and from inductive to deductive and back (Merriam, 2009).

In this study, framework analysis was used to analyze data. Framework analysis is a systematic, flexible, and transparent matrix-based approach to analyzing data that is not tied to any specific methodology (Furber, 2010; Gale, Heath, Cameron, Rashid, & Redwood, 2013; Ritchie, Spencer, & O'Connor, 2003; Smith & Firth, 2011; Srivastava & Thomson, 2009; Ward, Furber, Tierney, & Swallow, 2013). It has been utilized in the

social and health sciences, including nursing, and most commonly for thematic analysis of semi-structured interviews (Gale et al., 2013). The transparency of framework analysis makes it an exceptional choice for beginning researchers with oversight from more experienced researchers since the matrix provides a straightforward way to follow the decision trail from raw data through to final interpretations (Gale et al., 2013; Smith & Firth, 2011; Ward et al., 2013).

Framework analysis follows five stages: (a) familiarization, (b) identifying a framework, (c) indexing, (d) charting, and (e) mapping and interpretation (Parkinson, Eatough, Holmes, Stapley, & Migley, 2016; Srivastava & Thomson, 2009; Swallow, Newton, & van Lottum, 2003; Ward et al., 2013). Using the methods described in *Doing Qualitative Research Using Your Computer* (Hahn, 2008), the researcher utilized the Microsoft Office suite to code, index, chart, and analyze data. This method was an operational and cost-effective means for organizing data but allowed the researcher to maintain responsibility for identifying themes and analyzing data. Use of this method allowed the researcher to use familiar software that aided in data management and organization of the processes.

Familiarization refers to immersion in the data. A transcriptionist was hired to transcribe interview data. Familiarization was accomplished by reading the transcript while listening to the interview recording to ensure accuracy. Next, the transcript was read through in its entirety to achieve gestalt. Then the transcript was read through several times line-by-line to extract meaning. Throughout the readings, notes were made of ideas or recurrent themes (Parkinson et al., 2016; Srivastava & Thomson, 2009; Swallow et al., 2003).

Identifying the framework allowed the researcher to organize the data in a meaningful way that would make accessing the data simpler in future steps of the process (Parkinson et al., 2016; Swallow et al., 2003). The framework was established by a priori concerns and emergent issues raised during familiarization (Parkinson et al., 2016; Srivastava & Thomson, 2009; Swallow et al., 2003; Ward et al., 2013). The process of identifying the framework was flexible and iterative and time spent immersed in the data guided the development of the framework (Ward et al., 2013). During this time, it was important to assess the meaning and relevance of issues and make connections. It was also important to ensure the research questions were being fully addressed (Srivastava & Thomson, 2009).

Indexing involved organizing the transcribed data into the framework categories by “systematically applying the framework to each interview transcript” (Parkinson et al., 2016, p. 119). The thematic framework established in step two was numerically indexed for ease of use and key themes were coded into the data in a Microsoft Word file. As suggested by Parkinson et al. (2016), “other” categories were used within the framework and reviewed frequently to identify changes or additions needed to the framework.

Charting involved moving the indexed data into a Microsoft Excel worksheet and summarizing the data to facilitate mapping and interpretation (Parkinson et al., 2016; Srivastava & Thomson, 2009; Swallow et al., 2003; Ward et al., 2013). Charting organized the data into codes (columns), cases (rows), and summarized data (cells; Gale et al., 2013). This reduced data and allowed for analysis by case and by code (Gale et al., 2013). Use of this format also allowed the researcher to identify gaps “at a glance.” Difficulty in this stage lay in summarizing a participant’s responses from the entire

interview for a particular theme while maintaining the integrity of the voice of the participant (Parkinson et al., 2016). Use of “Q” and a specific page number of the transcript within the chart helped identify relevant direct quotes.

Lastly, mapping and interpretation were where cases were compared, patterns and connections were identified, and structures materialized (Swallow et al., 2003). In this stage, the researcher moved from the mechanics of the data to the intuitive viewpoint (Parkinson et al., 2016). This was the most difficult step in the framework analysis due to its interpretive nature but was strengthened by the transparency of the analysis, guidance from the committee chair, and member checking with key informants. The result was a schematic diagram of the phenomenon that guided the researcher in identifying the nature of what existed and the reasons for its existence (Parkinson et al., 2016). Metaphors were used to present a picture of the attitudes of acute care nurses toward nursing students with disabilities (Merriam, 2009). Mapping and interpretation also provided a basis for reliable recommendations or strategies based on the responses of the participants (Srivastava & Thomson, 2009).

Ritchie et al. (2003) stated framework analysis “allows researchers to move back and forth between levels of abstraction without losing sight of the raw data” (p. 220). The inherent audit trail in this approach ensures links between the original data and the interpretation (Smith & Firth, 2011). This transparent and iterative approach was the basis for choosing framework analysis for this study.

As the study progressed and themes began to emerge, the researcher identified key actors to review identified themes to ensure the voice of the participant. Merriam (2009) and Fetterman (2010) stated this process of member checking helps to advance the

analysis of the data and fill the holes in descriptions. This also served as part of triangulating to give credibility to the study.

Assumptions

The following assumptions were relevant to this study:

1. The volunteer sample is comprised of nurses in acute care facilities who have at least two years' experience precepting students in the clinical setting.
2. Responses received from the participants accurately reflect their personal beliefs (thoughts), feelings, and behavioral intentions.
3. The participants answered all items openly and honestly.
4. The culture of acute care nursing influences the nurse's individual attitude toward nursing students with disabilities.

Limitations

The limitations of this study were common to qualitative research studies. First, the small sample size might lead to a lack of generalizability. Data collection continued until saturation to allay this limitation. Secondly, accuracy of data analysis was tied to the experience of the researcher. Computer-assistance, member-checking, and peer review were utilized to mitigate this limitation. Lastly, credibility of the participants was not guaranteed. Use of the computer-assistance, in-depth analysis, and saturation ensured any outlying information was identified and analyzed appropriately.

Delimitations

This study was confined to clinical nurses in an acute care setting with at least two years' experience precepting students.

Establishing Rigor

Rigor refers to the overall quality and strength of a study even though it differs between quantitative and qualitative research. Lincoln and Guba (1985) asserted that *credibility, transferability, dependability, and confirmability* adhere more closely to the naturalistic approach to qualitative research than do the equivalent quantitative terms of *internal validity, external validity, reliability, and objectivity*. These criteria are essential for a qualitative research study that is rigorous and trustworthy.

Credibility

Credibility (or internal validity) questions how research findings match reality. Merriam (2009) pointed out that due to the interpretive, ever-changing nature of reality, it can never be grasped itself. Therefore, in qualitative research, access is gained to the participant's interpretations of reality through interviews, which might well be the most credible form of internal validity (Merriam, 2009).

To ensure credibility, the researcher used engagement in data collection, triangulation, member checks, and peer examination to compare and cross check the data. During data collection, the researcher sought data saturation and alternative explanations (Merriam, 2009). The use of alternative explanations strengthened credibility by challenging expectations and emergent findings.

Triangulation was accomplished by using framework analysis to check the findings of each case against one another. Member checks and peer examination were conducted periodically throughout the data collection and analysis process to ensure the researcher correctly interpreted and analyzed the data. Specific interviewees were approached during and at the end of the study to give feedback on the current

interpretation of the materials. Also, the dissertation chair was asked to review and give feedback on the analysis as it progressed and once the researcher felt it was complete. This strengthened the study's credibility by providing feedback to the researcher that might expose a concept that was overlooked or misinterpreted.

Transferability

Transferability (or external validity) describes how generalizable the results of a study would be, i.e., will the concepts found in this study be the same in different settings and with different participants? In focused ethnography, the aim is to describe a specific subculture within a specific context but the results should be transferrable to other members of the same group. Rich, thick descriptions and variation were utilized to support transferability in this study (Merriam, 2009).

Descriptive and reflexive notes were taken during and after audio-recorded interviews. These notes were added to the transcript to enhance the description of the interview. As discussed previously, variation was used to enhance transferability. Typically, ethnographic research is conducted at one site but since the purpose of this research project was to discover the attitudes of acute care nurses, it was decided to use nurses working at multiple sites to collect the data. This strategy kept the findings focused on acute care nurses in general instead of a description of a single specific site.

Dependability

The stability or consistency of finding over time is dependability (reliability) (Lincoln & Guba, 1985). Lincoln and Guba (1985) recommended using a decision trail and the assessment of researcher bias and the design of the study as ways to increase dependability. The framework analysis method was transparent and thereby provided an

inherent decision trail throughout the data analysis process. The researcher also kept a reflective journal and consulted with the dissertation chair throughout the research process to allow input to strengthen dependability.

Confirmability

Confirmability refers to the accuracy of the data and its meanings (Lincoln & Guba, 1985). One important aspect was to present the research in the voice of the participants instead of the voice or bias of the researcher. Reviewing audio-recorded interviews and reading the transcript simultaneously helped to ensure the transcription was accurate and allowed for notation of any nuances. Use of framework analysis allowed the researcher to constantly compare the raw data with interpretations to ensure data accuracy. In addition, member checking aided in confirming the presented interpretation truly represented the voice of the participant.

Ethical Considerations

Marshall and Rossman (1989) suggested the researcher ask these questions to judge the ethicality of the research strategies: “Will the strategy violate the privacy or unduly disrupt the world of the participant? Are they putting themselves at risk or in danger by participating? Will it violate their human rights in some way” (p. 75)? The researcher addressed these questions in various ways throughout the research process to ensure the study was conducted ethically.

Initially, IRB approval was obtained. All participants were made aware of the purpose of the study and how data were to be collected. Anyone was able to opt out of the study at any time by notifying the researcher that he/she no longer wanted to participate. Additionally, participants were informed they could request the recording be

stopped at any time if they chose not to continue or wish for a particular response not to be recorded.

All participants contributing to the interviews completed an informed consent form (see Appendix D), which outlined the study's purpose, procedures, confidentiality, voluntary nature, risks, and benefits, and a form containing demographic data. The signed consent and demographic information were kept separate from the rest of the study data in a locked filing cabinet in a locked office.

Some individuals interviewed had a disability. The researcher ensured language and behavior during the interview processes were inclusive. If a participant voiced discomfort or became emotionally distressed during data collection, the interview would have been immediately stopped.

Journaling notes did not contain identifying information except for the individual's pseudonym. Recorded interviews were kept on a facial-recognition protected laptop and transcribed interviews had all personal information redacted with only pseudonyms used to identify participants. Advice was sought from the dissertation chair and committee for any ethical issues that arose during the research process.

Conclusion

In conclusion, this study examined acute care nurses' attitudes toward nursing students with disabilities. There was limited research on nursing students with disabilities, and none done in the United States focusing on the acute care environment. The purpose of this study was to describe acute care nurses' attitudes regarding disability, how they were impacted by the acute care culture, and what significance they had for behavior. Because so little has been researched in this area and it was focused on a

specific culture that could have a significant impact on this population, a focused ethnography approach was chosen. The research was conducted in two south central states utilizing acute care nurses who had precepted students in the clinical setting for at least two years. Data were collected through interviews with precepting acute care nurses. Data analysis followed the framework approach to ensure transparency and flexibility. Rigor and ethical considerations that might have impacted the study were also addressed.

CHAPTER IV

FINDINGS

Little research has been conducted to date on how nurses in the acute care setting viewed nursing students with disabilities. With the focus of clinical education on acute care nursing, the purpose of this research was to explore the attitudes of acute care nurses toward nursing students with disabilities. The participants were interviewed, their narratives analyzed, and their own words used to illustrate each theme that emerged from the analysis.

Participants

Of the 20 participants, 17 were female and three were male. Each participant was assigned a pseudonym to protect their anonymity. Participant ages ranged from 28- to 50-years-old with a mean age of 38.1 years. Years working as a nurse ranged from 3 to 26 with a mean of 9.6 years. Participants had been preceptors from 2 to 17 years with a mean of 6.6 years. Eight held an associate's degree in nursing, nine held a bachelor's degree in nursing, two had obtained a master's degree in nursing, and one held a Doctor of Nursing Practice degree. There was representation from several units in both rural and urban hospital settings: medical/surgical (6), emergency department (5), women/children (3), intensive care (4), and pediatrics (2).

Defining Disability

At the beginning of each interview, participants were asked what disability meant to them. Ninety percent of participants identified disability as a deficit, disadvantage, or lack. Gail described disability as “some sort of deficit in whatever area it is attacking.” Participants also described an inability to function and being other than “normal” as indicative of disability. Lora stated disability is “the lack of being able to function as a quote ‘normal person’ would.” When defining the term, disability was focused completely on the individual; no participants described disability in language consistent with the social model. Participants talked about a person not being able to function or being unable to complete tasks that others could. Donna defined disability as “not being able to function on an average or normal basis.” Some discussed specific physical, mental, or learning disabilities and focused on those. Others discussed disability in broader terms but still identified it as an individual disadvantage. No participants mentioned environment or culture in their descriptions.

Interestingly, 13 of the 20 participants had significant exposure to someone with a disability. Two disclosed learning disabilities of their own and one had a sensory disability. Twelve acknowledged having a family member with a disability, the majority of which were learning disabilities. Additionally, nine identified having a friend or co-worker with a disability and nearly every participant mentioned having a coworker with diabetes or hypoglycemia when that scenario was addressed. It was interesting that nobody identified diabetes as a disability at the beginning of the interview. Despite the prevalence of contact with individuals with disabilities, the overall definition of disability remained a negative and discriminatory connotation.

No participant recalled having any formal training related to working with someone with a disability; however, almost all thought it would be useful. Several did mention receiving training on cultural sensitivity, sexual harassment and discrimination, and caring for patients with disabilities. There appeared to be a complete lack of education regarding disability laws and rights for employees working with disabilities in these facilities.

Thematic Findings

Six themes relevant to the culture of the acute care environment emerged: Safety, Barriers, Otherness, Communicating to Meet Needs, Disclosure, and Student Versus Colleague. These themes illustrated the attitudes of nurse preceptors within the culture of an acute care environment. Using the language of the participants, the themes are described and illustrated.

During data analysis, an interesting paradox arose. Throughout the data collection and interview process, participants' speech patterns and affect were very positive. Interviewees projected very positive and inclusive feelings about working with students with disabilities. When asked how they would feel about having a student with a disability, participants voiced it would not be a problem and they would be fine working with a student with a disability. They also separated themselves from nurses with whom they worked and who they thought would not be accepting of such a student. However, when the interview transcripts were analyzed, many of the thoughts and behavioral intentions of the participants were actually negative and, at times, discriminatory. Participants voiced concerns regarding physical barriers and safety. While communication to meet the student's needs was discussed, the intent to disclose the

disability to coworkers and faculty without the student's consent was also mentioned. Additionally, participants drew a strong distinction between their willingness to host a student with a disability and simultaneously believing a nurse with the same disability could not work on their unit.

Safety

Concern for patient safety was verbalized throughout the interviews and identified as a priority. The possibility that a student with a disability would be unable to hear a patient or alarm, be unable to move a patient safely, or make errors in judgment were all concerns for those interviewed. Nikki stated, "Are they going to be able to give effective patient care? That would be my biggest concern as far as patient safety goes." Safely responding to codes or other emergency situations was also discussed. Edward discussed both sensory and motor disabilities as detrimental in a code situation stating, "There's those scenarios that they could be ineffective at, which always goes back to CPR. You know, whenever there's a code blue scenario."

Interestingly, the nurses interviewed also brought up concerns for staff safety and the safety of the student. Staff safety was addressed primarily through concern that a student with hearing loss might not be able to hear someone's call for help and therefore not come to assist. Someone with a neurobiological disorder who was "unable to pull their own weight" was also identified in relating with staff safety. Participants also indicated a need to "protect my license" from someone who might make errors in judgment. In addition, the nurses interviewed expressed concern for the safety of the student. They did not want the student to do anything that might cause them harm or put them in a situation that would be uncomfortable or problematic. Jacquelyn stated, "They

need to take care of themselves, whether that be stopping during med pass, even though that's a very busy time, because the patients will still be there. The meds will still be there, and they need to take care of themselves first." Participants wanted students to feel empowered to take care of themselves if needed. Cassie indicated that a focus on student safety affects patient safety by stating, "We would want the student to be taking care of themselves. For the safety of the student and then [the] safety of the patients." While patient safety was identified as important, it was not given more focus than staff and student safety. All in all, safety was a priority concern for the participants as stated by Isabella, "Let's be safe, and at the end of the day, let's do things safely so if we need to do things differently, we need to talk about that. And what's going to keep you safe, or keep me safe, or keep patients safe."

Barriers

Participants recognized physical barriers might make it difficult for a student with a disability to function effectively in the acute care environment. Many of these barriers would affect students with sensory or motor disabilities primarily. Concern regarding the ability of a student in a wheelchair to navigate the environment was mentioned. Many nurses identified small rooms, computers fixed at standing height, crowded work spaces, and inaccessible doors as major environmental barriers. Hope described one of these barriers in the ER where she works, "Space. Not necessarily their skill sets and what they're able to do, but space." It was also recognized that specialty units were often locked, requiring a code to be entered into a keypad, a badge scan, and the ability to manually open a door at the same time. Equipment such as IV poles, workstations on wheels (WOWs), beds, and auditory alarm and communication systems were identified

as barriers that would need to be addressed to accommodate a student with a disability. Bridgette stated, “You’ve got to be able to hear call lights.” Jacquelyn added, “The WOWs, how can they push a WOW and do the wheelchair? Would they be able to reach the computer in their wheelchair?” Peyton recounted, “They would have trouble repositioning patients, lifting patients, getting in our small rooms, getting around, getting IV pumps, reaching supplies.” While most identified physical barriers, a few participants also discussed accommodations that could be made such as using a reacher tool, telling the student when a call light was sounding, or having others assist with the work of lifting and moving patients.

Participants discussed emergency situations or codes as another barrier. Some, like Samuel, stated the student would simply not be able to participate: “I don't know how you'd ever say, ‘Run a code,’ or ‘Go to a code,’ or ‘Do chest compressions.’” Others discussed ways a student could participate and how they would get the student involved in things they could do effectively. Edward stated, “But that person [in a wheelchair] could, again, be assigned a task of being recorder... Or be that person at the drug cart.”

Many believed students with disabilities would not get the full experience of practicing in their unit and their involvement would be restricted or limited. This barrier would be imposed by the nurse either due to perceived limitations of the student or a perceived lack of time to accommodate. Opal responded of a student in a wheelchair, “She wouldn’t be able to do a lot of the things, you’d have to do them for her.” Maggie also discussed restricting what she would allow the student with a disability to do: “I would probably only give them one patient. Just because it's busy and that would

probably be all I had time to do.” Such concerns were expressed by participants from all units.

Otherness

Consistent with the way disability was defined by the interviewees, students with disabilities were described as “other.” They were often referred to as different than “normal” or “regular” nursing students. Some participants even referred to the student in a wheelchair as a “wheelchair nurse.” Students with disabilities were referred to as “they” or “them” or “those people.” Others talked about “hiding” the disability or “not showing they have a problem.” It was difficult for participants to understand how the student with a disability might be able to perform the job well, even if differently. Cassie described this fittingly when she stated, “We're used to taking care of patients in a wheelchair as opposed to working alongside of someone in a wheelchair.”

Participants did not identify a student with a hypoglycemic episode as other and, as stated previously, did not even recognize diabetes as a disability until the scenario was presented. At that point, many said they had, in fact, coworkers with a disability but had never considered it as such. In the scenario of the student with a hypoglycemic episode, the nurses interviewed changed what they said to more positive and care-taking phrases showing concern for the student. As Hope stated,

I guess it's better. It's not, like, a physical, you know, like something like you're in a wheelchair and you're--you know, it's like, okay, here, you can fix it--you can do something about it and function as a normal person, quote, unquote, then, okay, let's go.

Participants described encouraging this student to take a break when needed and to take care of themselves first. They viewed this disability as something that could be fixed.

They were much more open since this student could get better and go back to work.

Throughout the interviews, it was evident participants had different expectations for nursing students with disabilities than for students without a disability. Those who made an attempt at positivity in responding to the scenarios discussed protecting students with disabilities and marveled at their ability to do what was expected of nursing students in general. Edward demonstrated this when talking about his experience working with someone with a disability: “They can do anything if they're trained and taught properly and have the desire to do so. They can do anything.” And Frank stated of students with disabilities, “At this point they've adapted so well--you know, I don't--I don't think it's going to be an issue. Because, again, they're adapted, they can do some amazing things.” The idea that it was “amazing” for these students to carry out the expected function of a nursing student created a distinction between nursing students with disabilities and those without.

Communicating to Meet Needs

Many participants related that they loved students and loved to teach. Participants verbalized that they would work with the student, communicating about individual needs, and to help make the acute care experience a positive one. Isabella stated,

I would just have a good conversation, I think, beforehand. How can I help you during this experience? How can I help you to learn? Is there anything that you need from me differently to help you to meet your expectations of what you need to learn here? And just make sure there's a good way for them to communicate to me.

Intentions related to communication centered on the student's needs but also included teaching those things the student would be unable to physically do in the acute care setting. Participants discussed adapting their teaching styles and activities as the student needed and accommodating the student to the best of their ability. Lora stated,

I try to keep in mind that not all people learn the same and that different approaches are sometimes needed with different individuals to teach them the same thing. I think, as a preceptor, I've looked at having multiple ways of teaching one thing, instead of getting frustrated with a person.

Interviewees emphasized the importance of open, caring dialogue that would facilitate providing the best experience possible for the student nurse. Tamara discussed communicating with students to best meet their needs: "First off, we'd sit down and we'd talk about what it is the preceptee wants to accomplish while they're on the unit. The things that they wanna learn and then we can make a plan of action."

In addition, participants divulged some intention to communicate with the instructor about the student's disability. In some cases, such as Cassie's, they merely wanted to see what was needed to accommodate the student. Cassie recounted speaking with the instructor to better understand the student's needs: "I would want to speak with their nursing instructor... to kind of gain just a better background on [the student]. That would kind of help me, I feel like, be able to communicate with the student better and know how to educate the student better."

Disclosure

While communication with students to best meet their needs was framed positively, disclosure was not. Participants contended it would be important for everyone working with the student to be told about his/her disability. They believed it would be easier to be inclusive and to meet the student's needs if everyone working with the student was informed of the disability. Frustration was verbalized about not being informed of a disability beforehand. This came out in discussing previous experience working with someone with a disability. Maggie stated,

You know, if anything, it has upset me that nobody told us at first. Because I think disabilities you see, as far as like a physical handicap or disability that's very visual, everyone is aware of that. But then people come into the workforce, and they'll have a disability that maybe people don't know about, maybe they have PTSD, or they're blind, or they have ADHD. And so it's not visible to the naked eye and so, if anything it's just frustrated me that we weren't...the rest of the staff wasn't alerted to that, and that we couldn't make allowances for them, maybe we made them feel bad or not like part of the team.

She went on to discuss how this would be the same for a student with a disability and the importance of disclosing so needs could be met. Other participants also indicated they believed it would be important to let their co-workers know if a student had a disability. This thought was based on the premise that participants would be able to better help the student if everyone was aware of any limitations. Cassie stated,

I would feel like I would need to make sure that my coworkers – that we all understood what the disability was and understood the correct way to handle a disability among our unit. But like I said, I believe with the right communication among the staff members, I believe that we could make it a good experience for everybody.

Participants also mentioned that the student might have to disclose his/her disability to patients whether they wanted to or not to avoid patients thinking negatively of them. Edward indicated the intention to have the student disclose his/her hearing disability to a patient:

And in precepting them, just reminding them that whenever they go in to talk to a patient, if they're not understanding them that they may have to divulge their disability to them, even though they may not want to, because they don't want their patient to think anything differently.

Some interviewees stated they would talk to the instructor for more information about the student's disability. Abby stated,

I would probably come to the instructor and say, are you aware this student takes all this stuff? [I] would talk to the instructor about that student and say, "Are we absolutely sure this preceptee needs to continue today. And you sure you don't

want to have a talk with them about, you know, let's take this medicine at night instead of during the day?"

Others would address the student personally and offer ways to “fix” the disability, like recommending hearing aids or changing medication or meal times. Abby talked about her communication with a student with hearing loss stating, “I’m mean enough to suggest, ‘Hey, do you have hearing aids? Because that might benefit you in this job.’” No participant indicated any awareness that these activities related to disclosure were inappropriate and illegal.

Student Versus Colleague

As mentioned previously, participants expressed positive feelings about working with a student with a disability. For example, Isabella stated,

I welcome all students with open arms because it’s something to be learned. People think nursing is on your feet, moving around, walking around. But there’s so many different avenues of nursing. But in order to get to those positions, they have to go through nursing school. And so, nursing school has to allow them the opportunities to learn just like everyone else does, [even if] their ultimate [working] environment is going to be different.

Interviewees discussed taking the time needed to figure out what would work best for the student, adapting the environment to meet his/her needs, and providing any needed accommodations. This included things like giving the student more time with the patient, involving them in whatever way was possible, working within the facility to ensure access, and spending time reviewing skills and concepts to meet the student’s learning needs. Nikki stated, “You've just got to adjust to that person. Figure that person out. Figure out what works for them, and how you teach them, and then you just go from there.” Hope described her feelings about precepting a student with a disability stating, “As the preceptor, I feel like every student that comes in, their disability is that they’re a

student and they have a lot to learn. So, you just add something to that [and] change what you are doing.”

Interestingly, these accommodating attitudes did not extend to colleagues with a disability. Participants indicated that if the individual with a disability was there as a student, they could make things work but that the same person would never be able to work on their unit as a nurse. Their rationale was when the individual with a disability was in the facility as a student, the primary nurse retained responsibility for patients and could allow the student to do certain things and not do others. Colleagues, however, had to take responsibility for their own patients independently. Isabella recounted, when talking about someone with hearing loss who could not hear alarms in the emergency department where she works, “As an employee, it would be important to be able to compensate for that. But, as a student...the responsibility falls on the primary nurse and we’d be able to communicate that to them in other ways.” The implications for safety or taking too much time were viewed as exponentially more negative when talking about a colleague. Wendy said, “As a student, I’d be able to help you out, but when you become a nurse you’re going to have to find a way to do this effectively and quickly.” Concern about infringing on the time and workflow of other nurses was greater when talking about a coworker. Donna mentioned, “I don’t think they would be able to work effectively on our unit. I mean, we all help each other out, but it takes up a lot of time too.” Even those who mentioned previous experience working with someone with a disability spoke negatively when talking about a colleague with a disability. Frank discussed a colleague who worked on his unit who had a traumatic injury that caused a stroke after she became a nurse, “Honestly I don’t know if [she] would come in here and sat down...to interview

for a position. I'd like to say I would hire her. I can't--I would be honest...but luckily I knew her before, and I knew [she] was going to be sharp so it's not a problem."

Themes Related to Attitude

The discord among participants' feelings, thoughts, and behavioral intentions was fascinating. Participants recognized an imperative to be inclusive and that individuals with disabilities had the right to be educated and to work just as those without disabilities but when it came down to the logistics of accommodating the various disabilities, it was difficult for them to grasp. When discussing their feelings about precepting a student with a disability, participants expressed very positive outlooks. They said things like "Let's do it," "That would be fine," and "No problem!" Yet, when asked about what they thought about a student's ability to work effectively on their unit, they began to identify the student with a disability as other and recounted the barriers and issues with making it work. These barriers were described as insurmountable when they discussed a colleague with a disability in contrast to a student. Something very similar happened with behavioral intentions. While some indicated an intention to communicate with the student to effectively meet needs, many more suggested their intentions were to watch the student more closely, expect the student to prove him/herself before he/she was trusted in the clinical setting or limit his/her clinical experiences. Participants also indicated they would inappropriately and illegally disclose the student's disability or expect the student to disclose. This intent was not malicious but reflected a clear lack of education about the rights of individuals with disabilities.

Summary

While exploring acute care nurses' attitudes toward nursing students with disabilities, six themes emerged: Safety, Barriers, Otherness, Communicating to Meet Needs, Disclosure, and Student Versus Colleague. Data analysis revealed that although there were positive feelings about hosting a nursing student with a disability, thoughts and behavioral intentions were quite negative. Safety for the patient, staff, and student was identified as vitally important to participants. Nurses who were interviewed perceived multiple barriers to a student with a disability being able to practice effectively. Throughout the interviews, students with disabilities were viewed as other by the participants. Communication was identified as a way to improve students' experiences in the clinical setting and meet their needs. Disclosure was also addressed and it was found the participants did not understand what disability law had to say about the rights of someone with a disability and disclosing. Finally, the nurses interviewed were much more open to precepting a student with a disability than working alongside a nurse with a disability. These themes illustrated the thoughts, feelings, and behavioral intentions found in the acute care environment that made up the attitudes of acute care nurses toward nursing students with disabilities.

CHAPTER V

DISCUSSION

The purpose of this research was to understand acute care nurses' attitudes toward nursing students with disabilities. Andre and Manson (2004) found clinical experiences were a significant point of discrimination for students with disabilities so it was important to understand the culture of acute care nursing expressed through the attitudes of nurses. Twenty interviews were conducted with acute care nurses who were employed at seven different facilities in two south central states. All participants had at least two years' experience precepting nursing students. Data were analyzed using the framework method.

Themes that emerged provided insight into the culture of the acute care environment. According to Schwarz (2007), culture, society, and environment are significant factors in attitude formation. The social model of disability--which also focuses on culture, society, and the environment--provided the framework for the study and linked attitudes to creating a culture that impacted those with disabilities. Use of a focused ethnography in this case gave insight into the cultural perspective of acute care nurses and provided direction for a more inclusive practice (Butcon & Chan, 2017; Cruz & Higginbottom, 2013; Wall, 2015).

Most participants identified disability as an individual deficit, disadvantage, or lack. This was believed to be due to the focus of healthcare on the medical model. The

medical model takes a very individual view of disability and identifies it as something to be fixed or cured (Carol, 2002; Marks & Ailey, 2017; May, 2017; Northway, 2000; Wright & Eathorne, 2003). In fact, Scullion (2010) suggested “that replacing the word ‘disability’ with ‘illness’ in nursing research regarding disabilities would keep the meaning entirely intact” (p. 698). This medicalized view of disability was confirmed by the findings of this study, i.e., nurses were less comfortable with sensory, motor, and learning disabilities that could not be corrected and more comfortable working with those who had medical disabilities, such as hypoglycemia, that could be treated. This medicalized view of disability was individualized, focusing on the impairment of the individual. This was in direct contrast to the ADAAA directive to shift focus from the physical aspects of disability to the social and environmental issues supported by the social model of disability (Neal-Boylan & Miller, 2015, 2016).

While some participants described positive experiences working with individuals with disabilities in the past, their positive responses were focused on that specific disability and did not extend to other types of disabilities. This was congruent with what was found in previous research. Kontosh et al. (2007) and Wood and Marshall (2010) found nurses viewed specific disabilities more favorably if they had previously worked with a nurse with that disability. In the present study, participants who had a disability or a close friend or family member with a disability revealed a more positive response to a similar scenario in the study. This was also congruent with findings presented by Matt (2011) where a nurse’s experience with and degree of closeness to a disability led to more positive attitudes.

A lack of formal training regarding accommodating disabilities and disability law was described by all participants. This lack of education and knowledge was shown to perpetuate negative attitudes throughout the literature (Carney et al., 2007; Magilvy & Mitchell, 1995; Marks, 2000; Neal-Boylan, 2012; Vickerman & Blundell, 2010). Similar negative attitudes were also discovered in the current study--more so in connection with working with someone with a disability rather than precepting a student. Research on disability education and knowledge conducted to date focused on faculty and identified a need for understanding legal responsibilities (Zhang et al., 2010). Multiple studies indicated knowledge of disability law had a positive effect on faculty attitudes toward nursing students with disabilities (Milligan, 2010; Murray, Lombardi, Wren, & Keys, 2009; Rao, 2004; Sowers & Smith, 2004a). Tee and Cowen (2012) identified that supporting a student with a disability in the clinical setting also required an in-depth understanding of disability laws and how to accommodate. The findings in this study echoed the deficiency of knowledge regarding disability law and accommodating disabilities and suggested a need for further education and training.

One area in which the study participants were quite obviously lacking education and training was the issue of disclosure. While open and honest communication between the precepting nurse and the student with a disability could enhance the clinical experience and establish trust, disclosure was still protected. Disclosure is the sole right of an individual with a disability to inform others about the disability. Unfortunately, participants indicated it would be important for everyone working with the student to be aware of his/her disability. Rankin et al. (2010) presented that healthcare organization representatives reiterated the importance of disclosure in the context of clinical

placement. This creates a conundrum. Individuals with disabilities are often hesitant to disclose due to fear of discrimination. This is a valid concern as an undercurrent of discrimination, especially within the clinical culture, was reported in previous research (Luckowski, 2014; Morris & Turnbull, 2006; Neal-Boylan & Miller, 2015). Yet, to meet a student's needs and ensure his/her ability to perform effectively in the clinical setting, it might be important to disclose the disability. While nondisclosure is a right of individuals with disabilities, several participants verbalized the intention to require the student to disclose his/her disability or to disclose for the student. This intention was not only inappropriate but also illegal. It was no wonder students were hesitant to disclose a disability. Hong (2015) described that a student's hesitation to disclose was often due to a fear of lack of confidentiality. According to the responses of the participants, this hesitation would be well-founded in today's acute care environment. A clear lack of education and knowledge regarding the inappropriate use of disclosure was illustrated. This finding supported research that there is a definable lack of education and training on disability law and rights (Carney et al., 2007; Magilvy & Mitchell, 1995; Neal-Boylan & Guillet, 2008).

One of the reasons given in the study for disclosing a disability was the issue of safety. Consistent with previous research, ensuring safety was a thought on most participants' minds. Patient, staff, and students' personal safety were all concerns for these nurses. Concerns regarding patient and staff safety were revealed when talking about the student with a hearing impairment, one in a wheelchair, one with a neurobiological disorder, or one with dyslexia. Maheady (1999) found some unique clinical safety issues arose with students with disabilities and this increased concern

about the student's ability to become a competent practicing nurse. Other research described students with disabilities being considered unsafe in clinical practice by simply doing things differently or taking more time (Carol, 2002; Carroll, 2004). Neal-Boylan (2012) and Sanderson-Mann and McCandless (2006) stated that nurses often overestimated the impact of the disability before understanding the student's compensatory technique to practice safely. In the current study, participants were quick to voice concerns about what the student could not do instead of verbalizing intentions to communicate with the student to determine his/her comfort level with caring for patients on the unit. The participants tended to verbalize primarily negative thoughts about the student with a disability's propensity for practicing safely in the clinical setting.

Conversely, student safety, as opposed to patient safety, was the focus of beliefs about a student with hypoglycemia. Ensuring the student was taken care of and safe was foremost in participants' minds in this scenario. This had not been a finding in other research but correlated with Scullion's (2010) article that indicated the medical model led healthcare professionals to view disability as something to be fixed or cured. The fact that hypoglycemia could be easily corrected with a snack and rest placed it in a more positive, inclusive light even in terms of safety. This did not indicate it was viewed positively--only that it was something the nurse could "fix." This greater acceptance of disabilities that could be corrected was the epitome of the medical view of disability.

Since safety is such a focal point in healthcare, it is an important topic to focus on with all nursing students. Marks (2000) stated safety is important for all students and they should be watched more closely and have to prove themselves in the clinical setting,

not only students with disabilities. These same sentiments were shared by participants in the study.

In addition to safety, physical barriers were believed to be impactful for students with sensory and motor disabilities in the clinical setting. Most participants immediately focused on what the student would be incapable of doing instead of considering the student lived with this impairment. The possible inabilities of a student with a disability were oftentimes the initial focus (Collins, 1997). Some participants immediately began listing potential environmental modifications that would be necessary. However, employers are not legally bound to make such modifications to their physical environment for students in the way they are with their own employees. Rankin et al. (2010) identified that clinical facilities might find that accommodating a student with a disability created an undue hardship and could refuse clinical placement. Luckowski (2014) reported that students with disabilities were often disappointed because their clinical experiences were restricted due to their disabilities. Similarly, throughout the interviews, participants brought up emergent situations and questioned how the student would be able to participate in a code or other emergency. It was also mentioned that a student's experience might be restricted or limited due to a disability. In participant responses to many of the scenarios, it was evident that students with sensory or motor disabilities might have to justify their skill level and aptitude to overcome physical barriers more than other students.

Communication was identified as the primary strategy used to accommodate the student with a disability and overcome barriers. Participants associated effective communication with enhanced collaboration, support, and teaching. Vickerman and

Blundell (2010) identified that communication was important to the success of all college students with disabilities. Rankin et al. (2010) and Howlin et al. (2014) also identified effective communication and collaboration as vital for the success of students in nursing programs, especially in the clinical setting. Participants discussed the importance of an open and caring dialogue that would lead to adapting their teaching style and the activities of clinical to meet the student with a disability's individual needs. They also indicated an intention to speak with the instructor to better understand what was needed to accommodate the student. Communication to provide support for students with disabilities could have an enormous impact on their clinical experience. Students in Luckowski's (2014) study indicated the need to feel supported in the clinical setting and Magilvy and Mitchell (1995) reported that success for a student with disabilities equated to someone being willing to meet their needs. A focus on strengths, being given opportunities, and being seen as a nurse before a disability were all described in the literature as important aspects to the success of those with disabilities (Matt 2008; Sanderson-Mann & McCandless, 2006; Wright & Eathorne, 2003). Open, caring, and intentional communication could enable the acute care nurse to provide these to students with disabilities.

While communication to meet the student's needs was positive, positive feelings expressed by participants toward precepting a student with a disability were in direct contrast to the verbalized negative thoughts and behavioral intentions. This was congruent with what was found in the research on power and dominance. Researchers pointed out that even positive assumptions made by dominant groups might perpetuate negative words and behaviors toward the nondominant group (Berndt, 2014; Zlotnick &

Shpigelman, 2018). This awareness gave credibility to the contradiction the researcher felt between the positive affect and speech patterns when the interviews were conducted and the negative and, at times, discriminatory tone identified when they were analyzed. It also reinforced the student with a disability's feeling of otherness within the acute care environment. Students with disabilities are in a vulnerable position, especially within the acute care setting. Hong (2015) found many students with disabilities reported a mental struggle with whether it was worthwhile to disclose their disability due to the unpredictability of responses. Dailey (2010) also found nursing students with disabilities desired to find ways to fit in and not draw attention because of the disability. The perceived need to manage the disability and concerns that disclosure might lead to discrimination added to students with disabilities' feelings of otherness.

While describing their feelings about hosting a student with a disability as “no problem,” participants often referred to students with disabilities as different than “normal” or “regular” nursing students. Ultimately, nursing students with disabilities would like to be viewed as a nurse first and treated like every other student (Matt, 2008; Neal-Boylan & Miller, 2017). In research performed by Quinlan et al. (2012), the ideal was all students would be accommodated and the clinical setting adapted to provide everyone the best learning opportunities. In that case, no one would feel different or excluded. Unfortunately, that is not reality in the current acute care nursing culture. Acute care nurses described students with disabilities as other and, even in providing accommodations, indicated they would be singled out and treated differently.

The point was made during the interviews that nurses are accustomed to caring for people with disabilities, not working alongside them. Much research indicated the

basis of nursing practice, the medical model, upheld this idea of an individual with a disability as needing to be managed or treated (Andre & Manson, 2004; Carol, 2002; Marks, 2007; Marks & Ailey, 2017; May, 2017; Northway, 2000; Wright & Eathorne, 2003). Unfortunately, research also indicated that while the medical profession contributed to this discriminatory practice, nurses held significantly more negative attitudes than other health professionals toward individuals with disabilities (Beckwith & Matthews, 1995; Scullion, 2010; Tervo et al., 2004). The difficulty acute care nurses had in seeing the nursing student with a disability as a potential future colleague, rather than someone needing care, lent itself to creating an environment of exclusivity and otherness. Harma, Gombert, and Roussey (2013) identified otherness as “a perception of [someone else] belonging to a category that is quite separate from one’s own” (p. 314). Throughout the interviews, participants identified students with disabilities as different from themselves and with different expectations. Participants’ behavioral intentions were to restrict the student’s experience, watch him/her more closely, and ensure he/she proved themselves in the clinical setting. Some participants emphasized the impressiveness of completing things that would not be noticed if done by a student without a disability. This overreaction to the accomplishments of individuals with disabilities also contributed to the idea that they were different or “other” (Dailey, 2010; Murdick, Shore, Gartin, & Chittooran, 2004). Dailey (2010) pointed out in her study that behaviors of those around them, whether seen as positive or negative, might perpetuate feelings of otherness in nursing students with disabilities.

To perpetuate the idea of otherness, participants indicated that if the individual was there as a student, they could make things work but the same person would never be

able to work on their unit as a nurse. This was the most interesting and arresting finding in the study. No research focused on comparing nurses' attitudes toward nursing students with disabilities versus colleagues with disabilities. Studies focused on nurses with disabilities identified workplace attitudes as a massive barrier to success (Kontosh et al., 2007; Matt, 2011). In addition, Neal-Boylan et al. (2011) found acute care nurses with disabilities were at three times greater risk for retention problems than a nurse without a disability. Likewise, students with disabilities were affected by attitudes in the clinical setting (Wright & Eathorne, 2003). Participants indicated a student nurse would not have to take responsibility for patient care as this was still the primary nurse's responsibility. This allowed for freedom in assignments and expectations in the clinical setting. It was interesting to note that this perceived flexibility and freedom was also indicative of perpetuating the idea of the student with a disability as "other." When the student transitions to nurse, s/he must then take responsibility for his/her own patients and participants verbalized the support needed to be successful might not be available. Sanderson-Mann and McCandless (2006) indicated it was incumbent upon nurse educators to create a supportive clinical atmosphere for nursing students with disabilities. Nurse educators could serve as a moderator between the student and the clinical nurse to ensure the student's needs are met. Unfortunately, although Neal-Boylan and Guillett (2008) reported nurses with disabilities identified a supportive colleague as a significant contributor to their success in clinical practice, there was likely no avenue to ensure this support for the working nurse.

Findings Related to the Theoretical Framework

The current research contributed to the limited body of knowledge regarding the perceptions and attitudes of nurses toward nursing students with disabilities in the acute care setting. The social model of disability did not deny physical impairment but focused on impeding factors placed on individuals by society, culture, and the environment to create disability (Goggin, 2009; Haegele & Hodge, 2016; Kattari et al., 2017; Priestly, 1998; Raman & Levi, 2002; Symons et al., 2012; Taylor, 2005; Yagmurlu et al., 2009). In this model, the term disability was not related to any lack or impairment in an individual but was a socially-created issue. Because of the social model's focus on the impact of culture and society, the phenomenon of power and how members outside of the dominant group were made to feel other than the norm was an important part of the model (Young, cited in Priestly, 1998). This cultural view of the social model of disability focused on social structures, including attitudes, which inherently impacted the material view of disability as well including physical accommodations (Anastasiou & Kauffman, 2012; Gabel, 2010; Priestly, 1998). Therefore, the attitudes of acute care nurses impacted all aspects of the experience of a nursing student with a disability in the acute care setting.

Findings Related to the Research Question

Attitudes and culture share a symbiotic relationship within society where each influences the other. In this study, attitudes or beliefs, feelings, and behavioral intentions of acute care nurses were consistent with the problem of socially-created disability. Participants demonstrated the power imbalance by recalling several common nursing tasks that would be impressive if completed by the student with a disability. This

overreaction to accomplishments would lead to increased feelings of otherness in the nondominant group. In addition, increased concern for safety, restricted experiences, watching more closely, and the need of students to prove themselves verbalized by participants propagated the idea of otherness. One nurse even went so far as to imply that if hospitals could “pick and choose,” they would not hire nurses with disabilities. The nurses interviewed also illustrated the pervasiveness of the medical model on the culture of nursing. In many cases, they indicated instinctually that they would switch from the role of educator/mentor to the role of care-taker/provider when faced with a student with a disability.

Most participants who responded positively to having a nursing student with a disability related more closely to the culture of disability because they either had a disability themselves, were close to someone with a disability, or had worked with someone with a disability. These positive attitudes were related to the societal and cultural influences of exposure to disability. In some cases, the positive feelings expressed were countered with negative beliefs or behavioral intentions that invalidated the initial positivity.

Furthermore, environmental factors were also discussed in relation to students with disabilities. The obvious physical barriers were identified as significant for those students with sensory and motor disabilities. While barriers were identified frequently throughout the interviews, accommodations and adaptations were rarely discussed. Another environmental factor brought up was the fact that other nurses on the unit would have a more negative view of the student. This would most definitely impact the student with a disability’s experience and feelings of otherness when learning in these facilities.

Limitations

This research had the following limitations. It was a qualitative study conducted in only two south central states. While every effort was made to include participants with a range of backgrounds and experiences, the results might only be generalizable to nurses with like characteristics and in like circumstances. Nurses who chose to take part in this study might have different views and experiences from those who chose not to participate. In addition, there were three male and 17 female participants, which made the representation of males slightly higher than the current 9.8:1 ratio of female to male nurses in the United States (Kaiser Family Foundation, 2018). While the researcher attempted to touch on the gamut of disabilities that might affect nursing students, two participants brought up addiction as a disability and another two brought up blindness. These were not included in the research as they fell under the categories of nonvisible sensory disabilities and psychosocial disabilities, respectively. These disability categories were addressed in the scenarios about hearing loss and the neurobiological disorder but differing attitudes about these conditions might not have been captured. Finally, participants might have altered their responses to be socially acceptable.

Implications

This study, which focused on acute care nurses' attitudes toward nursing students with disabilities, had implications in several areas. It addressed the attitudes of those in healthcare organizations hosting students for clinical, which has not been addressed in the United States to date. The results of this research might influence nursing education, practice, and research.

Nursing Education

Understanding the essentially negative attitudes expressed by acute care nurses toward nursing students with disabilities has implications for nurse educators. From the current study, the impact of the culture and environment of acute care nursing could be seen through the attitudes toward students with disabilities. These findings could be used to impact change in how educators teach and oversee students with disabilities. It could also be used to develop educational programs for acute care nurses to promote understanding of disability law and rights.

In light of the impetus to diversify the profession of nursing, nurse educators should work closely with the student, disability services, the healthcare organization, and the precepting nurse to ensure the student has the accommodations and support necessary to be successful in the clinical setting. Frequent communication and collaboration with all parties involved could promote positive attitudes and a cooperative learning environment for the student with a disability. Additionally, nurse educators could provide knowledge and resources to acute care nurses and other members of the healthcare organization regarding disability laws and the rights of the student. This sharing of knowledge and resources would not only benefit the student with a disability but also the acute care nurse and the culture of acute care nursing. The curriculum for schools of nursing should be considered and student learning outcomes assessed to determine the importance of acute care clinical in meeting the objectives of the program. With nearly 50% of all nursing jobs being filled outside of acute care, nurse educators need to review clinical requirements and determine if they are meeting real-world

demands. Being able to reduce the reliance on acute care facilities for clinical experiences would increase inclusivity for many individuals with disabilities.

Lastly, nursing has long been identified as the caring profession. Unfortunately, this caring attitude seems not to extend to colleagues with disabilities. It is imperative that the culture of nursing be changed to a more inclusive social model. This begins in nursing education. Nurse educators should model inclusivity and accommodating behaviors to all students. This change in the culture of nursing education would impact not only students with disabilities but any student who identifies as other and, eventually, the culture of nursing as a whole.

Nursing Practice

First and foremost, nurses in acute care need specific and frequent training in working with individuals with disabilities as colleagues and not only as patients. Nurses in this study were more accepting of a nursing student with a disability than a colleague with a disability. No participants verbalized having any formalized training on disability law, disability rights, or accommodating and working with someone with a disability. This lack of education contributed greatly to the negative attitudes discovered in this study. Effective training could have an extremely positive impact on these attitudes and the culture of nursing.

As discussed previously, there is a push for a more diverse nursing workforce. The need for individuals with disabilities to remain in or enter the nursing workforce is imperative. These trailblazers could reverse negative and historical attitudes and lead the way in changing the face of nursing to be more inclusive. Not only would this impact the profession of nursing but also those for whom we care.

Nursing Research

This study was the first of its kind conducted within the United States; therefore, it would be important to replicate this study. In addition, observation of nurses working with students or colleagues with a disability would add more depth to the understanding of acute care nurses' attitudes toward nursing students with disabilities. Examining the effect of a disability rights and law training program for acute care nurses would allow for further research on the impact of such a program. Gaining an understanding of the implicit biases nurses hold toward individuals with disabilities might lead to ideas that would allow the affective domain to be reformed. Further research is also needed on the difference between attitudes toward nursing students with disabilities and attitudes toward nurses with disabilities.

Summary

The purpose of this research was to understand acute care nurses' attitudes toward nursing students with disabilities. Acute care nurses' attitudes were defined as their beliefs, feelings, and behavioral intentions. Although some positive statements were made in the interviews, overall attitudes toward nursing students with disabilities were negative and discriminatory. Limitations were consistent with those common to qualitative studies. The study aligned with the tenets of the social model of disability by considering society, culture, and the environment, rather than the impairment, as creating a disability. The culture of acute care nursing was found to impact students with disabilities through the attitudes held by practicing nurses. Implications for nursing education and practice were identified. There were multiple recommendations for future research that would contribute to this limited body of knowledge.

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APPENDIX A

PERSONAL INTEREST IN DISABILITY STUDIES

Creswell (2013) explained the importance of reflexivity in qualitative research. The ability to understand the researcher's background and interest allows the reader to more fully understand the focus of the study (Creswell, 2013). In direct contrast to the positivist paradigm guiding quantitative research, reflexivity requires the researcher lay it all on the table and expose assumptions, biases, values, and prejudices to allow for critical appraisal (Northway, 2000). Due to the oppression associated with disabilities, it was imperative the researcher abandoned objectivity and actively engaged in the research process (Northway, 2000).

My interest in disability studies began during my master's program in 2010. My mother, who was the disabilities coordinator at a university, called me one day and asked if we would accept a student in a wheelchair into our nursing program. My immediate response was "No, it would be impossible for the student to navigate in med-surg clinical. They couldn't even get into the medication room at our local hospital. There is no way they could be successful." She continued to insist that there were accommodations we could make to enable the student to be successful in the nursing program, and I continued to point out all the barriers. Then she asked, "What if this was Larra (my daughter) and all she had ever wanted to do was be a nurse? What would you do to make that happen for her?" My response was "Whatever it would take." This is when I began to realize the barriers that students with disabilities must face on a daily basis in our education system.

In addition to this experience, I have several individuals close to me who have (or had) differing disabilities. My cousin was injured in an automobile accident and is paraplegic. After his accident, he completed his college degree and has worked in the

Social Security Administration, as a math teacher in a high school, and as a welder. He continues to hunt and fish and learned to water ski after his accident. He has even been skydiving! My late husband suffered for several years with crippling anxiety and depression that eventually claimed his life. My stepson has several mental and learning disabilities and requires a constant advocate in the school system. There is nothing I want more than for him to be given the chance to pursue what he loves and succeed in life.

As I began to study more about nurses and nursing students with disabilities, I was able to meet several individuals with disabilities who have thrived as nurses. I have also been able to advocate for my students who have disabilities and fight for their right to be in the nursing program. At times, I still wonder how we would accommodate certain disabilities but I know that with open-mindedness and a focus on caring for the individual there are very few that could not be successful in a nursing program. I am passionate about this topic because it has been understudied and is misunderstood among many faculty and clinical facilities. Furthermore, with the continuing rise of students with disabilities entering higher education along with the persistent nursing shortage and the impetus for more culturally competent care, it is an area that could benefit nurses and the profession of nursing greatly.

APPENDIX B
INSTITUTIONAL REVIEW BOARD APPROVAL



Institutional Review Board

DATE: October 18, 2018

TO: Kristy Calloway, PhD(c)

FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [1320445-2] Acute care nurses' attitudes toward nursing students with disabilities

SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS

DECISION DATE: October 18, 2018

EXPIRATION DATE: October 17, 2022

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Nicole Morse at 970-351-1910 or nicole.morse@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX C
LETTER OF INVITATION TO PARTICIPATE

Letter of Invitation to Participate

You are being asked to participate in a research study conducted by Kristy Calloway, MS, RN, CNE from University of Northern Colorado. You were selected to participate in this study because you are a nurse in the acute care setting and have precepted nursing students for at least two (2) years. This study will examine attitudes of acute care nurses toward nursing students with disabilities. The number of students in higher education who have a disability is increasing. Nursing schools rely heavily on acute care clinical experiences to educate future nurses. The research conducted on nursing students with disabilities has focused on the student and the faculty. There have been very few studies considering the perspective of acute care nurses. A better understanding of this phenomenon can help to strengthen the education of students with disabilities in the future and may also impact nurses working with disabilities. The study is anonymous and your participation is voluntary.

PURPOSE OF THE STUDY

The purpose of this study is to understand acute care nurses attitudes toward nursing students with disabilities.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following:

1. Contact the primary investigator Kristy Calloway at [REDACTED] to set up an interview.
2. Acknowledge that you have read and understand the study purpose, and what you can expect if you choose to participate.
3. Sign the informed consent document.
4. Complete a short demographic survey.
5. Complete the interview in person or via web-conferencing which will take more approximately one hour.

POTENTIAL RISKS AND DISCOMFORTS

The risks of participating in the interview are no greater than those experienced in everyday life. The only potential source of discomfort is the subject of the survey. You are free to exit the online survey at any point. If you wish to discuss the subject matter further, please contact the primary investigator Kristy Calloway at [REDACTED].

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Your participation in the research may result in increasing your comfort level with supervising nursing students and working with nurses with disabilities. You may also opt to have your name entered into a drawing for a \$50 Amazon gift card.

The benefit to society will be in providing information regarding factors that affect the experience of nursing students with disabilities in the clinical setting. This understanding may be used to develop educational programs to mitigate these factors.

CONFIDENTIALITY

All interviews will be kept strictly confidential. You will be assigned a pseudonym and any identifying information, such as names of schools, facilities, peers, etc., will be changed for the protection of your identity.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may discontinue the interview at any time without consequences of any kind.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact: Kristy Calloway, primary investigator, at [REDACTED].

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal rights because of your participation in this research study. If you have questions regarding your rights as a research participant, contact the University of Northern Colorado Institutional Review Board at 970-351-1910.

APPENDIX D
CONSENT FORM FOR HUMAN PARTICIPANTS
IN RESEARCH

UNIVERSITY of
NORTHERN COLORADO



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Acute Care Nurses' Attitudes toward Nursing Students with Disabilities

Researcher: Kristy Calloway, MS, RN, CNE

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Research Advisor: Darcy Copeland, RN, PhD, Dissertation Chair
Gunter Hall 3250
School of Nursing
College of Natural and Health Sciences
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Darcy.Copeland@unco.edu

The purpose of this study is to understand acute care nurses' attitudes toward nursing students with disabilities. As a participant in this research, you will be asked to answer interview questions about your experience with and knowledge of nursing students with disabilities. This research may give us knowledge that will benefit students with disabilities and the profession of nursing in the future. The interview questions and answers will be audio-recorded and notes will also be taken. The interview will take place at a time and location that is convenient for you. The initial interview is anticipated to take approximately an hour and a follow-up interview may be requested to verify data. The interview questions will ask you to describe your understanding of and experience with disabilities and will provide scenarios to understand your perception of nursing students with differing disabilities.

Any information obtained during this study which could identify you will be kept strictly confidential. During transcription and analysis, you will be assigned a pseudonym known only to the researcher and research advisor. Any other identifying information, such as names of instructors, peers, students, establishments, institutions, cities, etc. will be changed for the protection of your identity. All data will be kept on a facial recognition-protected computer or in locked file cabinets in the researcher's office. All data will be stored for three years after the study is complete. The information obtained in this study may be published in scientific journals or presented at scientific meetings, but the data will be reported in anonymous form. Your decision to participate will not be shared with your employing institution.

The risks inherent in this study are no greater than those normally encountered in activities of everyday life. The minor risk of participating would be the time commitment for the interviews. There may be some emotional discomfort to answering questions about a sensitive subject. You have the right to stop the interview at any time and withdraw from the study should the process become too uncomfortable for you. You may also elect to resume your interview at a later time. Information gathered in this study will benefit the population of nurses and nursing students with disabilities by allowing a greater understanding of the attitudes of acute care nurses toward nursing students with disabilities. You may benefit from participating in this study by increasing your comfort level with supervising nursing students and working with nurses with disabilities as you share your experiences with the researcher. You also have the potential professional benefit of knowing you have contributed to the body of knowledge about acute care nurses' attitudes toward nursing students with disabilities.

There are no costs associated with participating in this study and there will be no compensation for participating in this research. You may opt to have your name entered into a drawing for a \$50 Amazon Gift Card.

Participation is voluntary. Please feel free to ask any questions you may have about the study. If you have questions at a later time, you may contact Kristy Calloway, Principal Investigator at [REDACTED]. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

I understand that I am free to refuse my consent or to discontinue my participation in the study at any time without consequence or penalty and my decision will be respected.

Having read the above and having had an opportunity to ask any questions, my signature below indicates that I have read the information provided, understand it, and have voluntarily decided to participate. A copy of this form will be given to you to retain for future reference.

 Subject's signature

Date

 Researcher's signature

Date

APPENDIX E
DEMOGRAPHIC INFORMATION

Demographic Information**Age:** _____**Gender:** M/F (please circle one)**Years as a nurse:** _____**Years as a preceptor:** _____**Highest degree earned:** _____**Do you have a disability:** Yes/No (please circle one)**Do you have a friend with a disability:** Yes/No (please circle one)**Do you have a family member with a disability:** Yes/No (please circle one)**Please describe the disability and your relationship with the individual:**

Unit: _____**Size of facility:** _____**Location of facility:** Rural/Urban (please circle one)

APPENDIX F
SEMI-STRUCTURED INTERVIEW PROTOCOL

Semi-Structured Interview Protocol

Generic prompts may be used if responses are limited or require clarification or further detail. The following formats will be used:

- What do you mean by _____?
- Can you tell me more about _____?
- Can you give me an example of _____?

Topic	Questions
Introduction and Purpose	<p>Thank you for taking time to talk with me today. I wanted to speak with you about nursing students with disabilities. I am interested in understanding acute care nurses beliefs, feelings, and behavioral intentions about working with nursing students with disabilities. There are no right or wrong responses. I simply want to know your thoughts.</p>
Verbal Consent	<p>My name is Kristy Calloway. I am a doctoral student at the University of Northern Colorado and am doing a research study under the direction of my dissertation committee. I want to review the informed consent that you signed before we start. I'd like to ask you a few questions about the culture and environment in which you work, what you think and feel about having a nursing student with a disability in that environment, and how you would respond to specific scenarios working with a student with a disability. This should take approximately one hour. A follow-up interview may be requested as the study progresses. Your participation is voluntary and you may stop at any time.</p> <p>This interview will be recorded. Your responses will be kept confidential and neither you, nor anyone you mention in the interview, will be named in any presentations, reports, or publications. The name of your facility will not be disclosed and will be referred to using a pseudonym. You will be assigned a pseudonym as well and this interview will be stored by that pseudonym only on a facial recognition protected laptop kept in a locked office. If you have any questions regarding your rights as a research subject you may call the number on your informed consent document.</p> <ul style="list-style-type: none"> • Do you have any questions before we start?
Background Questions	<p>START RECORDING</p> <ul style="list-style-type: none"> • Tell me about your current position. • Tell me about your training.

Main Questions

- What does disability mean to you?
- What is your first memory of contact with someone with a disability?
 - How has this affected your view of disability?
- Tell me about your experience working with someone with a disability.
 - How has this affected your feelings about working with someone with a disability?
- Tell me about your experience precepting a student with a disability.
 - How has this affected your feelings about working with someone with a disability?
- Tell me about any disability training you have had at your facility or on your unit.

I am going to give you some scenarios concerning nursing students with disabilities. You are the preceptor for the following students:

- A student with significant hearing loss who is adept at reading lips.
 - What are your beliefs about this student's ability to work effectively on your unit?
 - How would you feel?
 - What would you do?
 - What do you think others on your unit would say you should do?
- A student who uses a wheelchair due to a spinal cord injury.
 - What are your beliefs about this student's ability to work effectively on your unit?
 - How would you feel?
 - What would you do?
 - What do you think others on your unit would say you should do?
- A student who has a hypoglycemic episode during the a.m. med pass and requires immediate attention but is able to continue the day after blood sugars are stabilized.
 - What are your beliefs about this student's ability to work effectively on your unit?
 - How would you feel?
 - What would you do?
 - What do you think others on your unit would say you should do?

- A student who reveals to you she has a neurobiological disorder and is taking Depakote, Seroquel, and Prozac.
 - What are your beliefs about this student's ability to work effectively on your unit?
 - How would you feel?
 - What would you do?
 - What do you think others on your unit would say you should do?

- A student who explains that he has dyslexia and will need to review all meds and orders orally with you to ensure he has read them correctly.
 - What are your beliefs about this student's ability to work effectively on your unit?
 - How would you feel?
 - What would you do?
 - What do you think others on your unit would say you should do?

**Follow up
Questions**

- Do you have anything else you would like to add?
- Is there anyone else you would recommend that I contact?

Thank you

Thank you for your time!

- Do you have any questions?

STOP RECORDING