Educating EAL nursing students: the clinical experience

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Certificate of original authorship

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as part of the collaborative doctoral degree and/or fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Abstract

Increasing numbers of undergraduate nursing students in Australia speak English as an additional language (EAL). Although the benefits of a linguistically diverse nursing workforce are often noted in the literature, the discourse around EAL nursing students often centres on the challenges that students face in completing their degree. In particular, clinical placements (compulsory workplace experience) are often considered to be difficult for both students and their supervisors (clinical facilitators), who feel they lack strategies to effectively supervise EAL students. The causes of the challenges for both students and facilitators are often considered to be students' lack of English language ability or learning styles that are not suited to western style education.

Clinical placement is a critical site for learning. It can offer students opportunities to participate in key nursing activities, learn from more expert others, and learn the specialised language of nursing. Thus, challenges students face and facilitators' perceived lack of confidence in supervising students are problematic.

This study investigates the pedagogic practices of three facilitators, as they supervise EAL students during clinical placements. It is based on six weeks of fieldwork, where I observed and audio recorded facilitators and students during their daily practices in three different metropolitan hospitals in Australia. An ethnographic research design combined with discourse analysis enabled a macro analysis of the broader context and a micro analysis of talk-in-action, resulting in detailed insights into facilitator-student interactions.

This study is based on the view that learning occurs through social interaction and that students can be guided by an expert other to be socialised into the practices and language of nursing. Rather than focusing only on students' individual abilities and learning styles, this study focuses on how facilitators' pedagogic practices can provide access to learning opportunities, and encourage student participation.

I found that there are multiple learning spaces in hospitals, each of which is associated with particular learning activities between facilitators and students. These activities provide access to opportunities for learning core nursing skills, as well as for socialisation into the language of nursing. However, not all students had access to these opportunities.

This research proposes a new way of thinking about the supervision of EAL students in clinical settings. Rather than focusing on a lack of English language or cultural heritage factors, it proposes that what I call a guided spatial approach can maximise EAL students' opportunities for learning.

Chapter 1 - Introduction

When teaching on an undergraduate nursing programme some years ago, I received the following email from a student:

> Hi, dear Caroline, I'm [name of student]
>
> I have been going to clinic for three days. I thought I did not [do] bad. I'm working hard and I know what the register[ed] nurse asks me to do because I was a nurse in China. Thx for your help. I feel more confident when I'm talking.
>
> However, this afternoon, our facilitator assessed us one by one, and she told me "my english is so bad". wow, so depressing.
>
> Yes, I know I'm weak in speaking especially when I'm nervous. I know I need to practise again and again, so that I can reduce mistakes such as he don't xxx
>
> but……
>
> all in all, my first language is Chinese and I need the time to be familiar with the terminology.
>
> I attended the pronunciation courses last week and I just became a bit confident but now I'm so upset.
>
> why the teacher didn't encourage us. on the contrary, she made us feel we are so bad and ganna fail the placement.
>
> two days left... what can I do~
>
> (personal correspondence)

Two days later I received a second email in which the student explained that everything was now resolved and her facilitator was 'good'. I do not know what happened in those two days to change this student's experience.

The student is describing her clinical placement, that is, workplace experience in the hospital setting, which nursing students regularly undertake in the course of their degree. This correspondence is similar to a number of interactions I have had with students during the last ten years whilst developing and teaching language programmes for nursing students for whom English is an additional language (EAL). What began as a small programme with a handful of students, is now foundational to the undergraduate degree structure of a large metropolitan university, with approximately 60-80 students per year (San Miguel[1] et al. 2006; San Miguel & Rogan 2009). Through teaching, programme evaluations and research into students' experiences, I have gained a good understanding of what students consider to be the challenges of their early clinical placements and how they respond to them. However, prior to this study, I knew little about clinical facilitators' (supervisors in the clinical setting) responses to the challenges faced by EAL students, nor the interactions that occur during clinical placement. This research aimed to find out more about how students and facilitators interact in clinical settings.

The global increase in student mobility has been widely documented over the last decade. In 2010, there were more than 4.1 million international students worldwide, 52% of whom were Asian, with the majority from China, India and Korea. Australia was the second most popular destination for these students (Organisation for Economic Co-operation and Development 2015), where international students make up 10% or more of tertiary enrolments. In undergraduate nursing, the number of international students increased more than 500%, between 2002 and 2011; and in 2011, 15% of undergraduate nursing students were international (Health Workforce Australia 2013). Although no specific figures are available for nursing students' countries of origin, the majority of international students in Australian universities in 2015 were from China (Australian Education International 2016). Other countries represented in the top ten nationalities include Vietnam and Korea. Language programmes I have taught

[1] Previously, I published under the name Caroline San Miguel. All references to work by San Miguel in this thesis are my previous publications.

to nursing students over the last ten years mainly comprise students from these three countries. As well as international students, nursing degrees attract large numbers of local, overseas born students. Salamonson et al. (2012) investigated the diversity amongst the first year enrolment in nursing at a large university in Sydney. Of the 67% of students who participated in the study, 56% were born overseas. The majority of the overseas born students were local residents, rather than international students. Local students who have recently migrated to Australia and have had little exposure to spoken Australian English may face similar challenges to international students in adjusting to the spoken language of the clinical setting.

Attrition rates for nursing students in Australia and internationally tend to be higher for EAL students than for students who speak English as a first language (Salamonson et al. 2011; Salamonson et al. 2012; Symes et al. 2002). Salamonson et al.'s (2011) findings that nursing students from language backgrounds other than English were twice as likely not to complete their studies in the minimum time is striking. Taking measures to increase the retention of both international and local EAL students is essential for two reasons: firstly, to achieve equitable outcomes for these students; and secondly, to create a linguistically and culturally diverse workforce, which can help provide culturally appropriate care for the diverse populations now common in many western countries (Donnelly, McKiel & Hwang 2009; Klisch 2000; Kossman 2009). International nursing students are sometimes regarded as sojourners. However, many enter the Australian workforce on completion of their studies (Preston 2009), and thus represent an important source of skilled immigration for the Australian healthcare system (Salamonson et al. 2012).

However, concerns have also been raised that the language proficiency of EAL students may not be sufficient to provide safe care even upon graduation from Australian universities. Safe care is care that does not result in errors or adverse effects (Iedema, Piper & Manidis 2015). Since 2010, students who have not had five years of education in an English-medium educational institution have been required to attain a band 7.0 in all four skills of the International English Language

Test (IELTS), or a minimum of B score in the Occupational English Test for Nurses before they can register as a practising nurse (Nursing and Midwifery Board of Australia (NMBA) 2011). This level of attainment is framed in terms of patient safety, the Board stating that it is 'committed to best practice regulation that protects the public by ensuring nurses and midwives can communicate effectively in English to provide safe care to clients' (NMBA 2011, p. 1).

There is, as yet, little research into the effects of this testing in terms of how many graduating students will be able or unable to register. However, one small study found that students who enter university even with the required entry score of IELTS 6.5 may not achieve the required band 7.0 for registration (Craven 2012). Given the importance of international and local EAL students to the nursing workforce (as noted above), failure of nursing graduates to achieve the required language score may have implications for the workforce. Leaving aside the issue as to whether these tests are appropriate for assessing students' English language proficiency to practise as professional nurses (Sedgwick, Garner & Vicente-Macia 2016; Wette 2011), mandatory English language testing has focused students', academics' and clinical educators' attention on the importance of communication, and in particular, appropriate use of English. This increased attention to language can be seen in: the use of post enrolment language screening to identify students who need to further develop English language (Glew et al. 2015); the design of assessment frameworks to help clinical facilitators assess students' English language during clinical placement (San Miguel & Rogan 2015); and in curriculum changes to embed clinical communication, as well as academic language and literacy into nursing degrees (Harvey, Robinson & Frohman 2013; Hillege et al. 2014; Müller, Arbon & Gregoric 2015; San Miguel, Townsend & Waters 2013). My study extends previous research by investigating language and learning in the clinical environment. Students' performance in the academic context lies outside the scope of this study.

Sophisticated communication skills and a high level of spoken and written English language proficiency are necessary in clinical environments (Pilotto, Duncan & Anderson-Wurf 2007), and the clinical practice component of the nursing degree

performs a learning and gatekeeping function in this respect. During their placement, students interact with patients, families and other healthcare workers and perform clinical skills at varying levels of expertise. At the end of each placement, their performance is evaluated by the clinical facilitator and students can only proceed to the next placement if their performance has been satisfactory. Clinical placement can be stressful for many students (Gibbons, Dempster & Moutray 2008) but it can be particularly so for those of EAL background (Khawaja, Chan & Stein 2017), who may sometimes struggle to use appropriate clinical language and may not fully understand the expectations of their clinical facilitators, which can be based on cultural perceptions of what makes a good learner, and a good nurse (Rogan et al. 2006; San Miguel & Rogan 2012). EAL students also may sometimes feel discriminated against by clinical staff (Rogan et al. 2006) and other students (Jeong et al. 2011).

Clinical placement also socialises students into the profession and has been referred to as a significant life event that can influence decisions to remain in the workforce (Wong & Lee 2000). The quality of on-site supervision that students receive from registered nurses (RNs) and clinical facilitators has a profound influence on the kind of clinical experience students have (Chiang & Crickmore 2009; Dunn & Hansford 1997; Rogan et al. 2006; San Miguel & Rogan 2009). Clinical facilitators play a central role in students' learning and development of spoken language during their placement by encouraging them, providing feedback and debriefing students on clinical events (Malthus & Lu 2012). However, supervising EAL students on clinical placement can be challenging for clinical facilitators, who may have difficulties communicating with students, and feel they lack strategies to effectively supervise EAL students (Jeong et al. 2011).

Moreover, the role of clinical facilitators is complex, as they are charged with being both mentor and assessor and these roles can at times conflict (Bray & Nettleton 2007). As mentors, clinical facilitators can support students in their adaptation to the workplace, encourage them to reflect on their experiences, develop their confidence in the clinical environment, and help them resolve any problems with other clinical staff or workplace problems. As assessors, they need to assess not

only students' clinical skills but also their ability to communicate effectively with patients and staff. Thus, facilitators need to both support students in their socialisation into the Australian nursing profession and make judgements as to whether students are effective and safe practitioners.

This complexity of factors makes clinical placement a critical site for nurse education. Recent research has argued that clinical staff need better preparation for supervising students from culturally and linguistically diverse backgrounds (Brown 2005; Dickson, Lock & Carey 2007; Eyre 2010). However, in order to better prepare supervisors, more needs to be known about how and when clinical facilitators and EAL students interact, what clinical facilitators do to help students learn, and what role language and culture play during meetings between clinical facilitators. Most research in this area has been based on interviews and focus groups discussing experiences of clinical placement, mainly with students and a small number with clinical facilitators, as distinct from observing what happens. Little has been researched about what clinical facilitators do to help EAL students learn and what role language and culture play in their interactions with students.

The next section provides background information on the structure of clinical placements and the model of clinical facilitation used at the research sites in this study.

Clinical placement

All nursing students undertake clinical practice as part of their nursing degree. Whilst there are various models of practice, in Australia, the *Registered Nurse Accreditation Standards 2012* (the Australian Nursing and Midwifery Accreditation Council (ANMAC) 2012) stipulate that students need to complete a minimum of 800 clinical practice hours during their degree in order to register as a nurse. At the university where this study was located, first year nursing students participate in a one-week, full-time clinical placement in their first semester and a two-week placement in their second semester. The length of the placements increases to a total of eight weeks in second year and ten weeks in third year. Clinical placements are allocated to students and they often attend different clinical settings for each

placement. Each clinical placement is aligned with a theoretical subject and students must pass their clinical placement in order to pass the subject. In the first year, the focus of the present study, students participate in patient care, undertaking activities such as bed making; taking blood pressure; assisting patients to shower; and administering medication. Many of these activities are carried out under the supervision of an RN unless the RN is confident the student can undertake the task independently.

Supervision of students during their clinical placements can be challenging as it often takes place in busy, complex environments over short periods of time. There are several models of supervision, most of which involve students working with several experts, including their clinical facilitator and other nurses. The clinical facilitator has overall responsibility for the student but while students are on the ward they also work alongside qualified nurses to observe and participate in daily activities. The RNs who work alongside students are commonly known as buddy nurses. They are usually allocated on a daily basis to students during the clinical placement. The arrangement is informal in that buddies do not make formal assessments of students; there is no documentation for buddies about what students are expected to achieve during clinical placement; and buddies do not receive any remuneration for their role. However, a teaching role is considered an integral part of the role of RNs and in Australia is acknowledged in the professional competencies (Henderson & Tyler 2011). It has been stated that students may learn most from the buddy nurses they work with directly (Dickson, Lock & Carey 2007; Henderson et al. 2010). However, the quality of the relationship between buddy RNs and students varies greatly. Some have argued that nursing staff, who also have a heavy patient care workload, may not have the time required to work with EAL students (Donnelly, McKiel & Hwang 2009).

At the research sites in this study, a 'clinical facilitation' model was used with first year students. In this model, clinical facilitators are registered nurses who are employed by the university on a sessional basis to take the lead responsibility for students' learning and assessment during their clinical placement. A clinical facilitator usually works with a group of approximately eight students across a

number of wards in a health facility and so has to visit different wards to see the students during their shift. In this study, the term 'supervision' will be used to refer to the overall act of supervising students in the clinical professions without reference to a particular model of supervision. 'Clinical facilitation' will refer to the specific model described above. In documentation from the university where this study was carried out, the facilitator was described as a mediator between the student and the clinical facility (in order to maintain confidentiality of the sites and participants, a reference is not provided for this document). The role of the facilitator was described as helping students to achieve their learning objectives and undertake assessment requirements. Their role included supporting students by facilitating formal and informal learning, developing critical thinking, providing constructive feedback, and evaluating students' performance. A daily routine was suggested for facilitators in the guidelines, which covered all three roles. Activities included:

- visiting and working alongside students
- identifying learning opportunities and supporting students to make use of them
- monitoring attendance and punctuality
- ensuring students know the diagnosis of each patient
- monitoring students learning towards meeting objectives
- obtaining regular feedback from ward staff
- attending handover if appropriate
- monitoring student allocations to check students are working with appropriate supervisor and have an appropriate load
- reviewing students' written reports and verbal handovers
- keeping a diary of events, issues, and discussions relating to students' performance or critical events.

The guidelines also noted that EAL students may need focused support from facilitators to develop learning strategies and language skills. However, at the time of my research, there was no guidance as to how facilitators might help EAL students develop their language skills.

These descriptions from the guidelines illustrate the multiple roles that clinical facilitators play during students' clinical placement. These roles can be summarised as that of a mentor whose role is to support students in their placement, a teacher who can guide them in their learning, and an assessor who can be viewed as a gatekeeper to the profession. Nash (2007) similarly notes a wide range of activities for clinical facilitators including: assessing students' learning needs; organising learning activities; liaising with hospital and university staff; and organising briefing and debriefing sessions, which are daily group meetings between the students and clinical facilitator to discuss students' learning objectives and to reflect on daily experiences. However, little is known about how clinical facilitators engage in these activities, and particularly how they interact with EAL students.

Research aims and questions

This qualitative study addresses the paucity of research on the supervision of EAL students in the clinical setting. Drawing on six weeks of fieldwork, audio recordings of facilitator and student interactions, and interviews, the study investigates the pedagogic practices of three clinical facilitators as they supervise EAL students during clinical placement activities. The students were in the first year of their undergraduate nursing degree at a metropolitan university in Australia. The research is important as it responds to calls in the nursing literature to help culturally and linguistically diverse students achieve success in their nursing degrees. Cherry (2005), for example, argues that educators need to make changes to curriculum and teaching, including clinical teaching, to help students from diverse backgrounds succeed. In investigating the kinds of pedagogic practices that may hinder or benefit EAL nursing students during clinical placements, this research may result in better preparation of facilitators and students, which may lead to better clinical placement outcomes for EAL nursing students. The study focuses on the following questions:

1. Where, when, and why do facilitators and students interact during clinical placements?

2. What pedagogic practices/interactions are in evidence in clinical placement settings?

2a. What are the focal themes (topics) of these interactions?

2b. What nursing skills and tasks do students have opportunities to learn in these interactions?

2c. What professional and institutional discourses do students have opportunities to learn in these interactions?

2d. What opportunities do facilitators have in these interactions to assess students' clinical skills/tasks and students' use of professional and institutional discourses

3. To what extent do these pedagogic practices enable and/or constrain students' opportunities to learn about nursing and about the language of nursing?

The study bridges the two areas of nursing education and language education. Predominantly, this study will be of interest to healthcare educators who have an interest in student learning during clinical placement, and who are particularly interested in educating nursing students for whom English is an additional language. For that audience, the method of discourse analysis used to interrogate the data, and the second language learning theories drawn on in the study, may be unfamiliar. However, these theoretical perspectives and methods of analysis have been introduced and used in a way that, I hope, is useful for nurse educators. The study may also be of interest to language educators, particularly those engaged in teaching communication to healthcare students. Language educators may be familiar with the second language learning theories, but less familiar with concepts drawn on from nurse education. However, clinical terms and nursing concepts are

accompanied by explanations to enable readers from non-nursing backgrounds to understand the nursing specific content.

Organisation of the thesis

The thesis is organised in the following way:

Chapter 2, *Clinical placement: the experiences of EAL students and their facilitators*, situates the study within current literature on the experiences of EAL students in clinical placements, and of clinical facilitators as they supervise EAL students. Given the limited research about EAL students in nursing, studies that have investigated EAL students in other health professions are also reviewed. These studies mainly refer to overseas' qualified medical doctors.

Chapter 3, *Learning nursing - learning language*, situates the study within a theoretical framework that draws on sociocultural theories of learning, and second language research. The theoretical framework crosses a number of discipline areas. It takes a view of learning as a sociocultural practice and draws on concepts of community of practice and situated learning to investigate how learning occurs in workplace settings. It also draws on theories of language socialisation to consider how students learn the specialised discourses of nursing. Within a sociocultural framework, the role of the expert is considered in guiding students learning. I draw on literature from school education and second language research to investigate pedagogic strategies facilitators use that can create or constrain opportunities for learning.

Chapter 4, *Researching language and learning in clinical settings*, provides the methodological framework for the study and details the research design and methods of analysis.

Chapter 5, *Overview of key findings*, provides an overview of the key findings from a thematic analysis of field notes taken during observations, and of interviews with students and facilitators who participated in the study. This chapter sets the scene for the following chapters.

Chapters 6– 10 can each be read independently of one another. As one of the key findings of my research was that space was a critical element in the opportunities that students had for learning about nursing and the language of nursing, each chapter investigates one of the spaces on the ward. Each chapter analyses the activities that occurred in those spaces. Chapters 7-10 also include linguistic analyses of interactions that occurred in each space, drawing on transcripts of audio recordings. Each chapter:

- provides a brief literature review of previous relevant studies
- considers how students gain access to learning opportunities in that space
- presents a macro as well as micro analysis of activities and pedagogic approaches and strategies used by facilitators
- discusses the implications for learning and language within that space.

Chapter 6, *Corridor: gaining entry*, focuses on how the pedagogic approach that facilitators use can enable or constrain students' access to legitimate participation. The facilitator's choice of pedagogic approach can also enable or constrain students' access to learning opportunities with the facilitator, where the facilitator focuses explicitly on socialising students into the shared repertoire of the community of practice.

Chapter 7, *Patient room: practising nursing,* demonstrates the complexity of the patient room as a learning space for students. It shows that students gain few opportunities for practising small talk, a key professional discourse, when facilitators are present.

Chapter 8, *Corridor: thinking like a nurse,* illustrates how facilitators can create a pedagogic space in the corridor for a follow up discussion to bedside observations in the patient room. This chapter focuses on the language that the facilitator uses to help scaffold students' thinking to complete nursing documentation, and make clinical decisions about patient care.

Chapter 9*, Nurses' desk: decoding patient notes*, illustrates two ways that facilitators adopt to help students read patient notes. These two approaches are reading aloud and reading alongside. It demonstrates how these approaches can help socialise students into a nursing discourse that is highly specialised and unfamiliar to students

Chapter 10, *Ad hoc spaces: end-of-day debriefing,* is written in two sections. **Section A** focuses on the pedagogic strategies facilitators use to help students reflect on their day. It compares strategies that are successful in engaging in reflections with those that limit student participation. **Section B** demonstrates how the end-of-day debrief can be used to socialise students into the discourse of a clinical handover.

Chapter 11, *Conclusion: rethinking clinical facilitation for EAL students,* summarises the key findings, outlining this study's contribution to knowledge, and discussing implications for nursing education.

Chapter 2 - Clinical placement: the experiences of EAL students and their facilitators

This chapter reviews research that has investigated the experiences of EAL nursing students and their clinical supervisors during clinical placement. It also reviews research that has focused on the communication requirements of the nursing profession, and the challenges that EAL students may face in the clinical context in meeting these requirements. The review includes all publications relating to EAL students that were found in a search of multiple databases. Alternative terms for EAL were used to widen the search; these include ESL (English as a second language); CALD (culturally and linguistically diverse students); NESB (non-English speaking background students); and international students. As there is limited research in this area, the review also includes several papers related to EAL medical students and EAL students in allied health. The review includes papers published in the disciplines of nursing education, applied linguistics, and medical or allied health education.

Learning the language of nursing

The previous chapter noted the importance of good communication skills in the clinical setting and the challenge this can pose for some EAL students. As well as playing a major role in socialising students into the profession of nursing, clinical placement is also an opportunity for students to be socialised into its professional discourses, that is, the particular ways of speaking, listening, reading and writing in that profession. However, learning these new discourses can be particularly challenging for EAL students who have to manage 'the complex, dual role of professional practitioner and language learner' (O'Neill 2011, p. 1127). Shrubshall and Roberts (2005, p. 6), drawing on Roberts and Sarangi's (1999) previous work on professional and institutional discourses, categorise the different discourses that nurses use as 'professional' and 'institutional'. Professional discourses are those used when nurses are primarily caring for patients, and when talking to colleagues about patients. Institutional discourses are those related to 'wider hospital networks' (p. 6), for example documentation such as care plans and

admission forms. Face to face interactions are usually central to professional discourses and written texts to institutional discourses. However, Shrubshall and Roberts (2005) also note that the lines between the two categories are not always clear. Nevertheless, these categories are a useful way of analysing the kind of discourses that are referred to in the literature reviewing EAL nursing students' experiences.

Professional discourses

Much of the literature focuses on professional discourses that students need to use during clinical placements, and the challenges that EAL students may face in using these discourses. Professional language with which students need to become familiar includes communicating with patients, which can include eliciting and providing information (Cameron 1998; Sedgwick, Garner & Vicente-Macia 2016); requesting actions, reassuring patients and engaging in social conversation (Sedgwick, Garner & Vicente-Macia 2016); negotiating taboo topics; and adopting strategies to best communicate with specific patients, such as children, patients who cannot hear well, or patients who are traumatised (Cameron 1998).

A major challenge for EAL students during clinical placement is to adopt the appropriate register, including the use of correct terminology, either specialised or lay terminology. During their placement, students need to be able to talk about nursing and medical information with patients, staff and other healthcare workers, as well as make small talk to establish rapport (Malthus, Holmes & Major 2005; Sedgwick, Garner & Vicente-Macia 2016). This means that students need to readily shift between different 'modes' of talk, for example, from using nursing and medical language when talking with professionals, to using everyday terms when talking with patients. At the same time, they need to be able to recognise those nursing and medical terms that have become part of everyday use. International medical graduates (students initially educated in their home country but completing graduate studies in another country) were found, for example, to have problems distinguishing between medical terminology used only in medical contexts to that which is used in everyday language, for example the term 'x ray', resulting in time spent explaining everyday medical terms to patients

unnecessarily (Dahm 2011). Students also need to understand meanings of sub-technical terminology, that is common words used with specific meanings in differing disciplines, for example, syndrome (Hsu 2013).

Some EAL students have been found to have difficulties understanding and adopting some of this language. Some problematic areas include: giving instructions or explanations to patients and understanding clinical handover reports (Crawford & Candlin 2013; San Miguel et al. 2006); understanding patients and colleagues (Crawford & Candlin 2013); and using nursing and medical terminology (Malu & Figlear 1998). Such difficulties with language in the clinical setting have also been found for EAL undergraduate medical students and international medical graduates (Hawthorne, Minas & Singh 2004; Pilotto, Duncan & Anderson-Wurf 2007).

Small talk can be particularly challenging for students as it often relies on unspoken cultural rules and unfamiliar colloquial phrases**.** However, making small talk with patients is part of the professional discourse of nursing, as it is important for establishing rapport with patients, to help put them at ease and to develop their trust (Sedgwick, Garner & Vicente-Macia 2016). Whilst experienced nurses have been found to make extensive use of small talk (Holmes & Major 2002; Holmes & Major 2003) little is known about how EAL students perform in this area. The only researcher who included observations of EAL students during clinical placements is Brown (2005), who noticed in her doctoral research that students rarely engaged in small talk with patients. However, observations were not reported in depth and Brown mainly drew on interview data to analyse student perceptions of their clinical experiences. San Miguel and Rogan (2009) also found through interviews with EAL students that small talk can be challenging. However, due to the lack of empirical studies of EAL students in clinical settings, little is known about the opportunities students do or do not have to learn these professional discourses, and what role, if any, facilitators play in helping them learn them.

Institutional discourses

Few studies have considered the challenge of institutional discourses for EAL nursing students even though novices are unlikely to be familiar with these highly specialised forms of discourse (Hobbs 2004). One body of work investigated how Francophone nurses learned how to write nursing documentation in an English speaking Canadian hospital (Parks 2000; Parks & Maguire 1999). However, those students had already completed their undergraduate training and were familiar with nursing documentation in their first language. To my knowledge, there are no studies of how novice EAL students learn about institutional discourses during clinical placement. What is known is that completing documentation is challenging for EAL students (Bosher & Smalkowski 2002; Dickson 2013; Donnelly, McKiel & Hwang 2009).

Integrating into the clinical setting

One of the challenges EAL students face is integrating into the clinical work setting (Mikkonen et al. 2016a). Difficulties in integrating seem to be due to a lack of clarity about role expectations (Rogan et al. 2006) and matters related to students' English language performance. Both EAL and non EAL students have reported confusion about their role as a learner or worker (Rogan et al. 2006; Spouse 2001; White 2010). Henderson & Tyler (2011. p. 289) argue that students can be used as 'another pair of hands' where buddy nurses might delegate 'simple hygiene activities to the student rather than directly supervise a student perform a complex skill or engage in patient interviews or education sessions where appropriate'. One of the roles of facilitators is to help students participate in learning opportunities. However, it is not clear how they do that. Some studies argue that facilitators expect students to take initiative and seek out learning opportunities (Donnelly, McKiel & Hwang 2009; San Miguel & Rogan 2012), and that this approach can be challenging for EAL students who may not be accustomed to a self-directed style of learning, and who may lack confidence in their English language performance (these studies are discussed in more detail below in relation to assessment processes).

In order to participate in clinical work, students need to be able to communicate with their buddy RNs and other healthcare workers to: understand what is expected of them; explain to their buddy RNs what clinical tasks fall within their scope of practice; understand and follow instructions; and build interpersonal relationships with their buddies. They also need to be able to communicate with their facilitator and peers. However, language difficulties can lead to students feeling 'different' and 'not fitting in' into the clinical environment (Brown 2005, p. 117). Although this sense of not belonging may be experienced by a majority of new undergraduate nursing students (Levett-Jones et al. 2007), it can be exacerbated for EAL students who need to adapt to the unfamiliar cultural, social and linguistic environments of clinical placements (Rogan et al. 2006). Furthermore, EAL students' language use can at times create friction with hospital staff, patients and other students. Students can find it difficult to follow staff instructions (Bosher & Smalkowski 2002), which can cause tensions with their buddy RNs. Students can also be perceived as bossy, abrupt or rude due to a limited use of softening devices or an inappropriate tone when giving instructions to patients (Brown 2005; Eyre 2010). Similarly, international medical students were perceived to be judgemental or not empathetic (Hawthorne, Minas & Singh 2004).

Students have reported feeling rejected by clinical staff and facilitators because of their level of English language, stating that facilitators did not want to listen to them because they did not speak well (Jeong et al. 2011). Clinical facilitators in that study also discussed the discrimination some students face. One facilitator recounted a story of an EAL student who had been bullied in a debriefing session. The EAL student was having difficulty communicating and another student responded with 'spit it out, spit it out' (Jeong et al. 2011, p. 241). Other students have reported being laughed at when they tried to clarify unfamiliar words (Brown 2005). Such events suggest that debriefing sessions may not always be regarded as a safe space by all students (Yang 2009). Recalling her own experiences as a student, Yang (of Hmong background), now a nursing academic states:

> While every student was encouraged and expected to participate, no explicit rules for sharing or role modelling were provided to assure

> participants that the dialogue would be respectful and non-judgemental. No guarantee was made that every student would be given time to speak. This type of post-clinical conference did not make me feel safe nor assured that I would be heard without being invalidated (Yang 2009, p. 106).

Apart from such incidents in debriefing sessions, students may also feel discriminated against by other nurses on the ward (Deegan & Simkin 2010; Jenkins 2009). Studies of undergraduate nursing students (Brown 2005) and overseas qualified EAL nurses who were participating in short competency based assessment programmes to gain registration in Australia (Jenkins 2009) have reported feeling that their performance was 'unfairly scrutinised' (Jenkins 2009, p. 7), and that their language was over-corrected. Similarly, overseas qualified EAL nurses have also reported that local nurses sometimes laughed at them during handovers and made faces behind their backs (Deegan & Simkin 2010). One clinical teacher in that study stated that a lot of staff treat EAL nurses 'as if they are completely stupid' and that some staff 'speak really fast and [do] not repeat themselves and then they just come and tell me that the student can't speak English' (p. 34).

These experiences suggest that the culture of the clinical setting is not always responsive to linguistic and cultural diversity and that the workplace setting of clinical practice may, like other workplaces, not always be conducive to language socialisation because of 'misunderstandings, racist comments, and the deliberate noncontact of some groups in relation to others' (Roberts 2010, p. 217). Events of this nature can clearly affect the performance of EAL students during clinical placement. Eyre's study (2010) of seven EAL students in their final year of a nursing degree found that that one of the important factors affecting their experiences was an inclusive environment. One of the roles of facilitators is to help students address some of the above challenges by helping them engage in the clinical setting by facilitating relations with ward staff, by clarifying learning expectations, and by creating learning opportunities. However, there is a dearth of research as to how facilitators help EAL students integrate into the ward and gain access to learning opportunities. Most research focuses on the importance of the

interpersonal relationship between facilitator and students and ward staff, rather than on pedagogic approaches and strategies that may help students integrate into the workplace, while at the same time focusing on their role as a learner.

Clinical facilitation: the interpersonal relationship

The quality of the relationship between supervisors and students has been described as 'probably the single most important factor for effective supervision' (Kilminster & Jolly 2000, p. 828). Developing good relationships between facilitators and students, and students and RNs, can influence the extent to which students become integrated into the clinical environment and may improve students' learning opportunities (Eyre 2010). Studies that have focused on EAL students' relationships with their facilitators have shown that students want positive relationships with their clinical facilitators and have clear ideas about the qualities that are important. They believe that clinical facilitators who are kind and helpful, who teach them by modelling behaviour and giving direct instructions, help them learn and communicate well (Eyre 2010; Lu & Malthus 2012; San Miguel & Rogan 2009). On the other hand, facilitators who put too much pressure on them, and who judge rather than teach them, hinder their learning (San Miguel & Rogan 2009). Although students' perceptions highlight the importance of the interpersonal role, they do not provide evidence for the kind of teaching that students found helpful. My study aims to explore the different kinds of teaching that facilitators engage in and investigate its effectiveness for helping students both integrate into the clinical setting and learn the professional and institutional discourses.

Although students value the interpersonal relationship with facilitators, they also stress the important role that they play in assessment. As one student in Rogan et al.'s (2006, p. 79) study said, 'we really need to know what's their opinion for our practice. I mean what is their expectations to overseas students and what will influence our results?'. The next section of this paper discusses assessment in the clinical setting.

Assessment during clinical placement

One of the key roles of clinical facilitators is to assess students' performance during clinical placement, including their English language performance. Students undertake a formative assessment approximately half way through their placement and a summative assessment at the end. However, clinical facilitators may also make judgements based on their interactions with students throughout the clinical placement. Their judgement of students' performance may be based not only on their own observations but also on comments made by RNs who work alongside the students.

At the time of my study, all Australian universities needed to comply with the national competencies for RNs in assessing students. These competencies were categorised into four domains: professional practice; critical thinking and analysis; provision and coordination of care; and collaborative and therapeutic practice (NMBA 2006). The competencies have since been replaced by seven national standards (NMBA 2016), which incorporate the above competencies. At the time of my study, individual universities developed their own assessment frameworks. In my study, students' performance in the four domains was assessed using a clinical assessment form that focused on the development of clinical judgement, that is a process of providing care for patients within a framework of critical thinking. The assessment form also included a list of clinical skills that students were to practise during the placement, if they had the opportunity (a copy of the assessment form is not included in this study to maintain confidentiality).

One of the standards for an RN is engaging in therapeutic and professional relationships (NMBA 2016). This standard incorporates communication with patients and health professionals. Assessing effective communication in clinical settings requires consideration of multiple factors, including English proficiency, specific communication techniques appropriate to patient-centred care, cultural knowledge and appropriate clinical skills (Wette 2011). The recent introduction in Australia of mandatory English language testing prior to registrations as a nurse, as noted earlier, has focused attention on the importance of communication, and in particular, appropriate use of English language during clinical placement. At the

research site for this study, English language proficiency was included on the clinical assessment forms as one of the criteria that facilitators needed to assess during each clinical placement. Until 2013, the assessment was a simple rating of English proficiency as 'yes' or 'no'. In 2013, a pilot project was implemented to trial a set of more explicit assessment guidelines about English language proficiency (San Miguel & Rogan 2015). These guidelines, which were introduced in response to clinical facilitators' concerns about assessing English language, describe three levels of English proficiency. Facilitators were asked to rate students' proficiency at one of these levels.

Assessing students' English language ability can be challenging for clinical facilitators who are rarely also language educators. There exists a wide, sometimes disparate range of assessment practices in assessing students' use of English language (Brown 2005). There is little reported in the literature about how clinical facilitators make decisions regarding language performance. Elder et al. (2012) investigated how health professionals assessed spoken clinical communication in workshops where they were shown video recordings of trainee-patient interactions. Elder et al. (2012, p. 416) found that health professionals tend to focus on health outcomes rather than language performance and propose that health professionals may 'give priority to clinical matters, because they feel that commenting on such features is beyond their competence, because they are blind to them (i.e., they lack the skills to make a linguistic diagnosis) or, more radically, because such features are irrelevant to what counts in clinical communication in their view'. In another aspect of this same study, Woodward-Kron et al. (2012) found that when feedback was given in a hospital setting to physiotherapy students, less emphasis was placed on communication skills than had been in the previous workshop held in a university setting.

One of the challenges in assessing spoken English language during clinical placement seems to be the difficulty in differentiating between language use and cultural differences. An analysis of the written comments made by clinical facilitators on students' clinical assessment forms (San Miguel & Rogan 2012) found that students were expected to have clear spoken and written

communication and to have a good bedside manner, which included qualities such as being courteous, polite and respectful. These qualities contribute to 'professional demeanour' (Jette et al. 2007, p. 838), a broad term encompassing 'the way in which an individual speaks, asks and dresses'. Professional demeanour is important not only in establishing rapport with patients, but also in building effective relationships with RNs and clinical facilitators, a factor, as noted above, which is also linked to positive clinical experiences for students (Eyre 2010; San Miguel & Rogan 2009). However, professional demeanour is a cultural construct, and differing cultural norms may lead to misunderstandings related to cultural expectations.

Assessment of students' performance can also be influenced by facilitators' expectations of students' behaviour during clinical placement. Clinical facilitators expect students to show initiative, take responsibility for their learning, ask questions, take criticisms well and show a willingness to learn (Donnelly, McKiel & Hwang 2009; San Miguel & Rogan 2012). However, students may be reluctant to participate in interactions with facilitators because they may view the facilitator as the 'big boss' (Rogan et al. 2006) and because asking for feedback from facilitators and other staff can be considered disrespectful by some students (Brown 2005; Eyre 2010). It may also be that students think their role is to watch the expert and learn, rather than to initiate patient care (Bolderston et al. 2008). Eyre (2010) found that students can also be reluctant to ask questions, as they are worried it could indicate a lack of understanding, which would prevent them from being accepted by clinical staff. Although Eyre (2010) focuses on students' relationship with clinical staff, it may also be a fear of displaying a lack of knowledge that prevents students from asking facilitators questions, given that facilitators make the final assessment of students' performance during clinical placement.

Similar difficulties in establishing professional relationships with other health care workers have been found amongst medical students in a study by Woodward-Kron, Hamilton and Rischin (2007). In that study, students reported difficulties with the use of first names between doctors and nurses as some of the students were accustomed to using titles to reflect status. They struggled with the apparent

lack of hierarchy and did not know who to ask for help. They also felt the teaching staff should initiate questions, rather than wait for students to ask questions. Such attitudes are also related to difficulties some students may have in adopting a self-inquiry learning style as shown in Malau-Aduli's (2011) Australian study of undergraduate medical students mainly from Malaysia.

These types of behaviours can influence clinical facilitators' perceptions of students' English language proficiency. In a study of supervisors' written comments assessing undergraduate medical students' clinical performance, Chur-Hansen and Vernon-Roberts (1998, p. 355) state that 'perhaps Asian students are regarded as having 'language problems' because they are not vocal and do not question their teachers, when in fact they are obeying cultural rules of respect' and propose that clinical supervisors may 'make unsubstantiated judgements based upon fragmentary information, or upon factors not necessarily related to English language proficiency, such as personality or appearance' (p. 354). Similarly, Brown (2005), found that some RNs assumed EAL students were bored and not interested in learning because they were quiet and had a neutral facial expression. Clinical supervisors in Brown's study also generalised Asian students as being quiet and non-communicative. These generalisations could affect students' language assessments if clinical facilitators expect talkative students who initiate interactions.

Such generalisations about cultural differences have been criticised by Yang (2009, p. 122), who says, 'I know I am a shy person, but I do not attach a connotation that this is an undesirable trait. Furthermore, I do not regard my quietness as unassertive'. She advocates that supervisors need to talk to students to find out what they think about these characteristics. Generalisations based on cultural differences have also been reported in the literature on international medical graduates. Hall et al. (2004) give an example of a woman who is expected to be quiet and reserved in her culture, qualities which can be misinterpreted in the Canadian context as unhappiness and a lack of confidence.

Misinterpretations about students' behaviour can also lead to negative judgements about their clinical skills. Ladyshewsky (1996) investigated the clinical supervision of EAL physiotherapy students. He found that supervisors expected students to express an opinion so they could evaluate the students' clinical reasoning skills. However, the students thought it more important to hear the expert's (i.e. the supervisor's) opinion and, as a result, were assessed as lacking clinical reasoning skills. In sum, assessing whether students' clinical performance is unsatisfactory because of limited English language proficiency or because of cultural differences in expected behaviours and attitudes can be complex and challenging for clinical facilitators.

A second challenging issue in student assessment is making decisions about underperforming students. It has been stated that there may be an unwillingness to document communication weaknesses 'due to lack of ability to clearly describe the problem or for fear of being seen as racist or bigoted' (Cross & Smalldridge 2011, p. e365). In one study that piloted an assessment tool with medical students (De Haes, Oort & Hulsman 2005, p. 588), no student received a negative grading of 'insufficient' in a two-year time frame, perhaps 'because raters are uncertain about their judgement, or afraid to take responsibility for the negative consequences thereof '. Similarly, one instructor talked about the difficulty of dealing with the process of failing EAL students in a subject, because 'if it goes to appeal or whatever, it's how much of this is language, and if it's language, should we not be giving extra leeway to the student. If it's safety, shouldn't we have pulled the plug earlier? So it becomes a real issue' (Donnelly, McKiel and Hwang 2009, p. 205).

A further challenge is for clinical facilitators to determine the extent to which students' performance might be affected by anxiety. As noted earlier, the facilitator has a dual role of mentor and assessor, which can cause difficulties for some students in interacting with facilitators (Brown 2005). EAL students reported feeling under pressure at completing clinical skills in a limited time frame while being observed (Brown 2005). This pressure and anxiety may result in underperformance.

My study investigates the opportunities facilitators have to make assessments about student' nursing performance, and within that, their performance in English language, as facilitators interact with students in the various spaces within the ward setting.

Clinical language programmes

In response to difficulties faced by EAL students, some universities have developed clinical language programmes (e.g. Bosher & Smalkowski 2002; Boughton, Halliday & Brown 2010; Button et al. 2008; Malthus, Holmes & Major 2005; San Miguel et al. 2006; San Miguel & Rogan 2009). These programmes consist of both face-to -face workshops and online resources and focus on preparing students for clinical placement by teaching them the language of typical clinical interactions. Some programmes are offered prior to students' first clinical placement, while others are offered after students have already experienced the hospital setting. Some universities have also reported working with clinical facilitators to introduce them to the challenges that EAL students may face and to provide some advice for facilitators (Hussin 2009).

Evaluations have shown that such preparatory language programmes can help students move from 'feeling excluded' to a sense of 'finding themselves' based on their growth in confidence and knowledge of what to do and say on clinical practice (Rogan et al. 2006). However, while these programmes can help students develop some key ways of communicating, they are limited in that they place responsibility on the student to develop skills and strategies to adapt to the clinical environment, without developing an institutional response that includes professional development of clinical facilitators.

Professional development for facilitators

As noted earlier, there have been numerous calls for professional development programmes which can assist clinical facilitators and other supervisors to better support students during clinical placement (Brammer 2006; Donnelly, McKiel & Hwang 2009; Dunn & Hansford 1997; Henderson, Barker & Mak 2016; McCarthy & Murphy 2008), and in particular, professional development that focuses on

supervising students from culturally and linguistically diverse backgrounds (Brown 2005; Dickson, Lock & Carey 2007; Eyre 2010). Salamonson et al. (2015) found that EAL students were less satisfied overall with their clinical experience, and in particular with how facilitators supported their learning, than were students who spoke English as a first language. Salamonson et al. (2015, p. 210) propose that this dissatisfaction could be due to facilitators being 'less skilled in meeting the situated learning in practice needs of EAL students'. One aspect of attending to these needs is the way in which facilitators and students talk with each other. Pitkäjärvi, Eriksson and Pitkälä (2012, p. 5) state that attention needs to be paid to methods that can be used to ensure 'safe communication' when 'a language barrier exists between a student and a preceptor' (a role that is similar to a facilitator). They argue that there is a need to develop strategies that support EAL students during clinical placement, proposing that 'tailored instruction which combines the subject matter and the language could form the core of such strategies' (p. 5). Similarly, O'Reilly and Milner (2015) argue that there is a need to identify effective strategies that can support EAL students in a range of clinical settings. They draw on suggestions from focus groups with students and supervisors. These include 'supportive placement delivery modes and structures; early expectation setting … visual aids and tailoring the learning environment' (O'Reilly & Milner 2015, p. 8). They also note that this support includes language support, as that is a critical factor in student success. However, they also note the complexity of the clinical environment and call for research that investigates what strategies are feasible within a clinical environment.

Similar calls for professional development have been made in the field of undergraduate and postgraduate medicine. Proposals for these programmes include educating staff on the cultural challenges faced by international medical graduates (Couser 2007; Hall et al. 2004); modifying programmes to suit a range of learning styles (Couser 2007); and providing staff with resources that can help them address challenges facing international medical graduates (Pilotto, Duncan & Anderson-Wurf 2007).

In a recent systematic review of studies that investigated the experiences of culturally and linguistically diverse students, Mikkonen et al. (2016a, p. 184) argue that as well as the importance of a good interpersonal relationship (as described above), EAL students need 'a well thought-out procedure to integrate them into learning in a clinical environment; particularly that students and clinical staff need additional time, cultural and language education, and support especially at the beginning of learning'. Overall, however, there is inadequate education for facilitators in supervising EAL students (O'Reilly & Milner 2015). Furthermore, there is little research that considers what this kind of targeted support for EAL students (that combines subject matter with language as mentioned above) within the clinical setting might look like. The proposed strategies to date are based on experience rather than empirical data that provide evidence of strategies that may be feasible and effective in the clinical setting. My research contributes to this gap in knowledge and responds to calls for research into methods that support EAL students and their facilitators during clinical placement (Mikkonen et al. 2016a; 2016b).

Conclusion

Facilitators play a key role in students' clinical experiences. As RNs with a dedicated education role, and in their position, as liaison between the university and the clinical environment, facilitators may have opportunities to: help students better integrate into the clinical environment; gain access to learning opportunities; and learn the professional and institutional discourses of nursing. However, as discussed above, many facilitators do not feel equipped to take on this role. There is a need for research that can contribute to an understanding of the complex role of the clinical facilitator. Interactions between clinical facilitators and students need to navigate the tensions created by the intersection of professional competencies, linguistic diversity and differing role expectations of students as novice learners and workers. More needs to be understood about how facilitators and students manage this complex terrain. Such research could inform the design of professional development programmes for facilitators who supervise EAL students.

Studies that explore learning in healthcare areas, although mostly not focused on EAL students, provide some insights into the role of social interaction in learning and the role that clinical facilitators may play in that learning. These studies draw on theories of socio-cultural and situated learning, which provide a framework for considering how EAL students learn during clinical placement, and what the role of language is in that learning. Other studies drawn from the field of second language research, in particular language socialisation, help explain the challenges and opportunities students may face in participating in clinical settings and how the role of the facilitator, viewed as an expert other, can help guide their learning. These theoretical perspectives are reviewed in the next chapter.

Chapter 3 - Learning nursing - learning language

The previous chapter reviewed literature related to the experiences of EAL students and their facilitator during clinical placement, including some of the key challenges faced by students. These main challenges include learning new professional and institutional discourses for nursing; gaining access to learning opportunities; and integrating into the workplace. Embedded within those is the additional challenge of working and learning in a language that is not the students' first language. The previous chapter also reviewed the important role that facilitators can play in providing students with a positive clinical experience and in helping them gain access to learning opportunities. Few of those studies have, however, considered how students learn during placements, how they learn the particular ways of communicating in nursing, and what role the facilitators' pedagogic choices plays in that learning.

There is an extensive field of research in the area of workplace education (e.g. Billett 2001; Gherardi 2006; Nicolini 2012). However, to date, that literature has tended not to focus on issues related to second language learners, and has to date not been applied to the area of second language learning and language socialisation. As the focus of this study is the pedagogic practices that enable and/or constrain EAL students' learning during clinical placements, the literature reviewed in this chapter draws on theories that have been widely used in investigating EAL learners. This chapter situates the learning and language learning that occurs for EAL students during clinical placement in this study, within a broad framework of sociocultural theories of learning, including language learning. The key theoretical perspectives drawn on are legitimate peripheral participation and community of practice; second language socialisation, which draws on theories of community of practice and legitimate peripheral participation; and the role of the expert other in working with students in their zone of proximal development (Vygotsky 1978) to guide their learning. It also draws on concepts from classroom based research in the fields of education and second language education to consider how students and facilitators participate in

interactions, and how that participation extends or constrains their potential for learning.

Due to the limited research in the area of EAL learners in healthcare contexts, it also draws on some studies from healthcare and applied linguistics that have investigated how novices who speak English as a first language are apprenticed into their profession, including learning the professional and institutional language of their professions.

Sociocultural views of learning

The shift from cognitive to sociocultural views of learning started when researchers undertaking studies in non-school contexts began to question the assumption that cognition was a general competence irrespective of social, cultural and historical situations. Scribner and Cole (1973) reviewed a number of cross cultural studies on learning and highlighted the different learning processes and outcomes in school-based situations and everyday situations across a variety of cultures. They argued that the cultural practices in these two different settings gave rise to different kinds of learning. Their arguments, along with other research (e.g. Lave 1988; Rogoff and Lave 1984; Scribner and Cole 1981) illustrated the limitations of a purely cognitive model of learning for explaining how learning occurred. For example, Scribner and Cole (1981) studied the literacy practices of Vai people in Liberia and found that specific types of literacy practices led to different forms of cognitive skills, highlighting the importance of cultural practices in developing cognition. In order to explain their findings, these scholars turned to the work of Vygotsky (1962; 1978) whose work on sociocultural historical theory was central to the shift from a cognitive view to a more socially oriented view of learning. Rather than viewing learning as acquiring a set of skills, knowledge, values and attitudes, which are then applied in practice, socially oriented perspectives view learning as a process that occurs through social interactions that are situated in particular social, cultural and historical contexts.

Legitimate peripheral participation in a community of practice

Lave and Wenger (1991) continued to extend this social orientation to learning by proposing the concepts of situated learning and legitimate peripheral participation within a community of practice, in order to explain how novices are socialised within particular communities. They drew on a number of case studies of apprenticeship to develop the concept of situated learning, according to which learning is a social practice. In situated learning, the focus is on the learner acting in a particular sociocultural situation, where 'agent, activity, and the world mutually constitute each other' (Lave & Wenger 1991 p. 33). Learning occurs through 'increasing participation in communities of practice' (p. 49). Lave and Wenger (1991) proposed the concept of legitimate peripheral participation to understand how learning occurs. This concept foregrounds the relational views that underpin situated learning, providing a 'way to speak about the relations between newcomers and old-timers, and about activities, identities, artefacts, and communities of knowledge and practice' (p. 29). Lave and Wenger (1991) stress that the concept of legitimate peripheral participation is a heuristic for analysing how learning occurs and is not a pedagogical strategy.

According to Lave and Wenger (1991), novices are apprenticed into the community by experts, who engage them in legitimate peripheral participation, that is, daily activities that are authentic to the setting but set at an appropriate level for the novice. The activities are peripheral and thus failure to complete an activity successfully will not cause irreparable damage. Lave and Wenger argue (1991, p. 37) that peripherality also implies 'an opening, a way of gaining access to sources for understanding though growing involvement' and that this access depends on 'the social organization of and control over resources'. Legitimate peripheral participation leads to 'full participation' (p. 37). In order to become a full member of a community, novices need 'access to a wide range of ongoing activity, old-timers, and other members of the community; and to information, resources, and opportunities for participation' (Lave & Wenger 1991, p. 101). As discussed in Chapter 2, many EAL students feel they have difficulties accessing learning opportunities, as they can find it difficult to integrate into the clinical setting (Mikkonen et al. 2016a). Analysing what enables or hinders novice

students to participate legitimately can provide insights into how students can access better learning opportunities during clinical placement, in order to move towards full participation.

Lave and Wenger (1991, p. 98) describe the community of practice as 'a set of relations among persons, activity, and world, over time and in relation with other tangential and overlapping communities of practice'. They are social structures that involve power relations and newcomers can pose a threat to old timers. In a community of practice, participants 'share understandings concerning what they are doing and what that means in their lives and for their communities' (p. 98). Lave and Wenger (1991) argue that members of the community of practice have diverse viewpoints, different interests, and make different contributions to activities. By participating in a community of practice, novices find out 'how masters talk, walk, work, and generally conduct their lives' (Lave & Wenger 1991, p. 95). Wenger (1998) further developed the notion of community of practice. Particularly relevant for this study is Wenger's (1998, p. 82) 'shared repertoire' that participants in a community of practice develop over time. This shared repertoire includes ways of thinking and speaking. Wenger (1998) also notes that key requirements of a community of practice are negotiation and joint enterprise.

In my study, there are multiple overlapping communities of practice. One community of practice is the broad profession of nursing. A second community of practice is the local one of the ward where students are placed. This community of practice includes the RNs on the ward. A third community of practice is one of student nurses who are undertaking clinical placement in that hospital. This community of practice includes their fellow students. In my study, the students are clearly novices and both the facilitator and the buddy RNs and other staff on the ward are the experts or 'old timers' in these overlapping communities (Lave & Wenger 1991, p. 29). All of these expert others play a role in how/whether students engage in legitimate peripheral participation that will move them towards full participation as a future qualified RN.

One aspect of legitimate peripheral participation relevant to the challenges nursing students may face in integrating into the ward and gaining access to learning opportunities is sponsorship. Spouse (1998a; 1998b), in a longitudinal study that followed seven nurses through the clinical experiences of their degree programme, noted the importance of a mentor's role in helping students gain entry to the community of practice. The language background of students in this study is not mentioned. Spouse argues (1996; 1998a, p. 348) that if sponsorship by a mentor is effective, the newcomer can acquire the language and skills of the community of practice and can recount stories that 'exemplify practice and their affiliation with the community'. Without sponsorship, engagement in any meaningful activity was difficult for the students in her study.

The mentor role in Spouse's research was somewhat different to both the buddy RN and facilitator roles in my study. Unlike the facilitators in my study, the mentors were members of the clinical ward where students were undertaking their clinical placement. In that way, the mentors were similar to the buddy RNs in my study. However, similar to facilitators in my study, mentors had a more formal role than buddy RNs. They were the main point of contact for students during their clinical practice; they had been appointed to a mentor role because they were 'recognised and respected as both knowledgeable and skilled in the area of practice in which … [they] would be mentoring' (Spouse 1996, p. 122); they had participated in a short induction programme; and they had access to ongoing peer support meetings. Unlike these mentors, the facilitators in my study were not part of the clinical team in the ward. However, like the mentors they need to play a role in helping sponsor students into the practices of the ward, by 'conferring legitimacy' (Lave & Wenger 1991, p.92) and helping students gain access to learning opportunities with their buddy.

Spouse (1996) identified five categories relating to how the mentors in her study helped students participate in the community of practice. Similar to studies reviewed in the previous chapter, the most important category related to the interpersonal aspects of supervision. Other categories Spouse (1996) noted were planning, collaboration, coaching and sense making. Planning involved identifying

and organising learning opportunities and selecting suitable patients. Collaboration was care that was provided by both the mentor and the student. Usually this collaborative care was initiated by the mentor with the student as assistant. The category of coaching was one category that Spouse (1996, p. 128) found was experienced only by a few students. In that category of activity, students were the key actor and the mentor 'supplement[ed] the student's performance by providing specific guidance or instruction'. Mentors mainly focused on practical skills when coaching. The category of sense making was characterised by 'a dialogue between student and … mentor, … with the intention of clarifying thinking, exposing areas of ignorance or confusion, sharing of worries or designed to give information relating to observed practices…' (p. 130). Spouse (1996) concluded that sense making was essential to students' learning as it provided them with opportunities to reflect on their own practice and to 'explore understanding' (p. 131) of things they had observed during their placement. However, she also noted that effective use of sense making required a high level of trust between mentors and students. Newton et al. (2015) also stress the importance of communication that helps students make sense of learning. However, they found in their observational study of nursing students and RNs that there were few examples of sense making. Rather, RNs communication was mainly task specific and 'performed in a rushed manner' (Newton et a. 2015, p. 95).

The above categories provide a valuable insight into how facilitators might sponsor students into the community of practice and help them participate. However, the categories were developed mainly from interview data with few observations of short duration in the clinical setting. Spouse (1996) did also not take into consideration the language background of students.

Similar to the mentors in Spouse's studies (1996; 1998a; 1998b), clinical facilitators have multiple expert roles in students' clinical placement. As discussed earlier, these roles include that of a mentor whose role is to support students in their placement, and a teacher who can guide them in their learning. Facilitators are also assessors who can be viewed as gatekeepers to the profession. Another similarity to the mentors described above is that facilitators may also play a key

role in helping students gain access to the community of practice and engage in legitimate activities with buddy RNs that are appropriate to their level of learning. However, as facilitators are visitors to the ward, and do not have a patient load, the way in which they sponsor students into the community may be different from the mentors described above in Spouse's (1996) study. Facilitators need to smooth the students' transition into clinical placement by establishing alliances with staff in clinical settings and selecting appropriate RNs for students to work alongside (Dickson, Walker & Bourgeois 2006).

One factor that may influence students' entry to the community of practice is the response they receive from healthcare workers and their clinical facilitator when they undertake clinical placement. Dickson, Walker and Bourgeois' (2006) findings about the facilitators' ability to influence the atmosphere and relationship between students and staff suggest they may play an important role in helping or hindering students from gaining initial social acceptance. Social acceptance could in turn influence students' engagement in the community of practice and hence their access to 'the linguistic tools of their communities' (Toohey & Norton 2003, p. 66). Studies of EAL students on clinical placement, as discussed in Chapter 2, have shown the difficulties students may have in navigating the linguistic and sociocultural norms of the placement to gain social acceptance.

Engaging in legitimate peripheral participation can be challenging for students. Existing studies (reviewed above) demonstrate how effective supervision can help students navigate these challenges. They demonstrate the usefulness of the notion of community of practice and legitimate peripheral participation to analyse the challenges that novices may face in gaining entry to the community of practice, and strategies experts use to help them participate in the activities within the community. However, the above studies have not considered how EAL students gain entry to the community of practice and participate in activities. EAL students may face particular challenges in accessing legitimate peripheral participation. EAL learners experience a 'double socialization' (Roberts 2010, p. 211), as they are socialised into the specialised discourses of the workplace as well as 'the specific language and cultural practices that realize these discourses'. The strategies

discussed above as proposed by Spouse do not explicate the relationship between language and learning, nor the particular language practices of the community that students are entering.

Although Lave and Wenger (1991) acknowledge the importance of language, one of the critiques of their framework is that it lacks a theory of language in use (Creese 2005; Tusting 2005). Lave and Wenger (1991) argue that the purpose of learning is not to learn from talk but to learn to talk and that this is a key part of peripheral participation. As noted above, Wenger (1998, p. 82) states that one of the characteristics of a community of practice is a 'shared repertoire' that participants in a community of practice develop over time. This shared repertoire is a resource for negotiating meaning in the community and includes 'routines, words, tools, ways of doing things, stories, gestures, symbols, genres, actions, or concepts' (Wenger 1998, p. 83). As Tusting (2005) points out, language is essential to negotiation. Existing studies that draw broadly on sociolinguistics demonstrate the value of paying attention to language, in order to illustrate, firstly, what the shared repertoire of communities are (including ways of thinking, speaking and writing), and, secondly, how language is used by experts to help novices learn to think, speak and write in particular communities of practice (Ajjawi, Rees & Monrouxe 2015; Eggins 2016; Erickson 1999; Ferguson 2010; Hobbs 2004; Pomerantz, Ende & Erickson 1995; Veen & de la Croix 2016). These existing studies focus on students for whom English is a first language (or the language background of students is not mentioned). To my knowledge, there are no empirical studies that focus on how language is used as a tool for learning in interactions with EAL students in clinical settings, nor how interactions between students and facilitators create or constrain opportunities for socialisation into the language of nursing.

A further criticism of Lave and Wenger's (1991) work is that it is 'overly dismissive of the role 'teaching' plays in the workplace learning process' (Fuller et al. 2005, p. 65). The facilitators in my study have a dedicated education role. The existing research that analyses the language of interactions between supervisors and students demonstrates that supervisors do teach (Ajjawi, Rees & Monrouxe 2015;

Eggins 2016; Erickson 1999; Pomerantz, Ende & Erickson 1995; Veen & de la Croix 2016). However, there is little research that focuses on the pedagogic strategies that supervisors use in the workplace for EAL students.

An investigation into the learning of EAL students in the workplace needs to take into account both how students gain access to the community of practice and how they get to participate in activities, as well as how expert others help them move from the periphery to full participation. In particular, it needs to focus on the language of the 'shared repertoire' of the community of practice, and the language used by facilitators to help students learn the discourse of nursing. Second language socialisation theories allow this dual focus on both learning and language in the workplace setting (Duff 2012). The next section of this chapter discusses second language socialisation and reviews existing research in workplace settings.

Second language socialisation

Second language socialisation builds on primary language socialisation research (e.g. Heath 1983; Ochs 1988; Schieffelin & Ochs 1986). Like situated learning described above, primary language socialisation also emerged from sociocultural theory and refers to 'the process by which novices or newcomers in a community or culture gain communicative competence, membership, and legitimacy in the group' (Duff 2007, p. 310). A key argument of language socialisation is that 'linguistic and cultural knowledge are *constructed* through each other' (Watson-Gegeo 2004, p. 339). According to socialisation perspectives, language learning is socially, culturally and historically situated; culturally organised activities and interactions are central to learning; and peers and experts play a key role in guiding novices in their learning (Duff 2007).

Second language socialisation research combines ethnographic, sociolinguistic and discourse analytic methods to carry out fine-grained analysis of language and culture learning in specific situations (Watson-Gegeo 2004). Duff (2007) notes the trend in second language socialisation studies to draw on the concepts of community of practice and legitimate peripheral participation to analyse processes that help or hinder novices to participate in communities. Using a community of

practice framework alongside micro-linguistic analysis helps focus attention on *how* novices learn to participate in the discourses of the community of practice; *how* they are explicitly or implicitly guided into these discourse; and *how* interactions between experts and novices help or hinder the process of gaining expertise (Duff 2007).

Roberts (2010) notes some of the limitations of language socialisation theory. There is a risk that communities can be seen as static with stable language practices. Original language socialisation studies were carried out in small communities that were more homogenous than are contemporary workplace communities. As a result of changes in the nature of work and of globalisation, language practices change. Duff (2003) also rejects the notion of static, homogenous communities with stable language practices, noting that communities where second language socialisation occurs tend to be complex, multilingual, dynamic and competitive. Nevertheless, as Roberts (2010) notes, existing second language socialisation research has found that there are relatively stable notions of what constitutes being a professional in particular communities. Linguistic research has found that there are particular ways of talking about patients, writing about patients, and making clinical decisions that novices need to learn (Holmes & Major 2002; Holmes & Major 2003; Malthus, Holmes & Major 2005; Parks 2000; Parks & Maguire 1999). My study focuses on how facilitators help students learn these ways of communicating. At the same time, the ethnographic analysis and the interviews with participants take into account the complexities of the workplace setting for learning these discourses. It pays attention to some of the tensions generated by power relations between RNs and facilitators; the lack of stability of buddy RNs due to the nature of shift work; and the different ways of practising clinical skills developed in the local community of practice of the wards compared with standard practices expected by the nursing profession as represented by the university.

As noted in Chapter 2, studies drawing on a variety of theoretical frameworks for analysing language and social interaction in context demonstrate how novices in communities of practice need to adopt a variety of 'modes' of talk in order to be

successful: what Roberts and Sarangi (1999) have identified as personal, professional and institutional talk. Second language socialisation studies have investigated how novices come to learn the particular ways of communicating within specific communities of practice. Roberts (2010, p. 213) provides an overview of studies of second language socialisation in the workplace, noting the 'rather meagre trickle of workplace and professional socialization research'. She argues that one of the reasons for this lack of research is the challenge of undertaking ethnographic, longitudinal studies that are based on naturally occurring data. Hence, she reviewed studies that include a 'rather elastic definition of language socialization research' (p. 213). My study provides a valuable contribution to research on second language socialisation in the workplace, as it was an ethnographic study that covered the entire clinical placement as students participated in the 'periphery' of nursing practice.

Second language socialisation draws on a range of theories of language in use to analyse, at a micro level, interactions occurring within particular communities, and between experts and novices as they learn to participate. An ethnography of communication developed by Hymes (1972; 1974) and interactional sociolinguistics are two common frameworks used for analysing language in use. These frameworks analyse interactions at both a macro and micro level and show how the 'community (and its culture) is constituted and constitutes itself through its participants' language use' (Creese 2005, p. 60). These two frameworks are discussed in Chapter 4. In my study, they are used alongside community of practice and legitimate peripheral participation to explore the role of language, as novice EAL nursing students gain access to, and participate in, activities during clinical placement.

Access to learning opportunities

Second language socialisation is dependent on access to opportunities to learn the particular discourses of communities (Norton & Toohey 2001). Not all workplaces offer equal access. Duff, Wong and Early (2002) found that different contexts foregrounded particular types of language socialisation. They studied the experiences of a group of adult immigrants in Canada, who were learning to be

long term resident carers in residential homes. In the classroom, students had learned formal healthcare terminology for work. However, in the two placements in residential homes, students had very different socialisation experiences. In one, the residents mostly did not speak English and students had to learn to communicate by using non-verbal strategies and by simplifying their language. In a second placement, the residents were mainly English speaking and students had many opportunities to be socialised into the informal everyday language of healthcare. The authors illustrate with their study how language socialisation occurs in complex, multilingual environments, and how different settings offer different opportunities for second language socialisation.

While Duff, Wong and Early (2002) illustrate how different types of language socialisation are offered across different clinical contexts, it may be that different spaces within the one clinical setting also extend or constrain differing opportunities for learning and language socialisation for nursing students. Recent years have seen a 'spatial turn' (Gulson & Symes 2007, p. 97) in workplace learning (e.g. Gregory, Hopwood & Boud 2014; Hopwood 2014), and language studies (e.g. Hadi-Tabassum 2006; Pennycook 2010), where space is viewed not as 'an invisible container for practices' (Hopwood 2014, p. 356) but as 'socially and materially produced' (Hopwood 2014, p. 356). Many of these studies draw on the work of Lefebvre (1991). Gulson and Symes (2007, p. 101) summarise Lefebvre's view of space as one where 'space is socially produced, engineered and constructed, and … [where] social relations are *always* constituted relative to space'. Whilst my research does not explicitly draw on and engage with these theories, it does attend to the social nature of spaces. In investigating pedagogic interactions and second language socialisation, space is analysed from the perspective of how students gain access to spaces; how students can participate in activities in different spaces; what learning opportunities are offered or constrained by spaces; and how participants, activities, role relations and frames, that is, 'what is going on in the space', are constituted by and constitute the spaces. Studies that have considered the use of hospital spaces are particularly relevant to my work and are reviewed below.

Existing research that focuses on medical students and on interprofessional health teams in hospitals has illustrated the importance of different spaces for learning and communication. Corridors have been found to be spaces where opportunities arise for 'ad hoc' teaching (Eggins 2016; Morrison et al. 2014; Pearce 2003) and where interprofessional teams meet to discuss patient trajectories (Iedema et al. 2006). Patient bedsides have been found to provide opportunities for senior doctors to guide junior doctors' learning in patient care (Ajjawi, Rees & Monrouxe 2015; Rizan et al. 2014); and meeting rooms away from patients have been used to help medical students develop a professional identity, as they discuss patient cases with a senior doctor away from the patient (Erickson 1999).

Spaces where health practitioners come together to discuss care have been described as 'action 'hot spots'' where learning can occur (Gregory, Hopwood & Boud 2014, p. 1). In a similar way, particular spaces may be 'learning hot spots' for facilitator and student interaction. Gregory's (2016, p.7) study found that 'nurses learn by redefining ward spaces into pedagogic spaces', and in particular, that they withdrew to private spaces away from patients. Iedema et al. (2006) and Gregory (2016) both draw on Goffman's concepts of frontstage and backstage, as hospital professionals seek to find spaces that are backstage, that is away from patients so they can discuss matters in private.

Concepts of space are particularly relevant for the way in which facilitators work with students in clinical settings. As noted in Chapter 2, students can find it challenging to manage the dual roles of worker and learner. Facilitators can use space to help students manage these roles and to help foreground the role of learners. Furthermore, as guests on the wards, facilitators do not have any spaces they can call their own. They need to seek out spaces where they can interact with students, whilst not 'interfering' with the daily activities of the wards. My study will demonstrate that at times facilitators may wish to work with students in 'frontstage' spaces, in front of patients and hospital staff. However, at other times, they may wish to work with students in 'backstage' spaces, away from patients and staff. Solomon, Boud and Rooney (2006) analysed where learning happened in the overlap of work and social spaces, for example, the tea room. They argue that

analysing everyday learning in spatial terms is a way of problematising workplace learning. In my study, space will be shown to have been an important angle for problematising the learning of novice students as they become socialised into the ways of doing, thinking and talking like a nurse. Within the ward setting, it will be shown that the patient room, the corridor, the nurses' desk, tea rooms, canteens and patient lounges offer different opportunities for learning about the practices of nursing, including the language of nursing.

Language as a tool that mediates learning: implicit and explicit socialisation

As well as the important role of language in learning *to* talk, language plays an essential role in guiding students in their learning, that is, in teaching them how to become a nurse. Learning is mediated by social interactions that are constructed by language, a language, which for the students in this study, is not their first language. According to second language socialisation theories, language is learned through others who are more proficient in language and cultural practices, via explicit and implicit mentoring (Duff 2007). As noted previously, Lave and Wenger (1991) consider the role of a mentor or an 'old timer' essential in helping students or novices learn in those situations. They argue, however, that novices learn not necessarily from the 'master' but that the master plays a role in helping novices gain access to learning by 'conferring legitimacy' (p. 92) and thereby creating opportunities to learn. Second language socialisation enriches the notion of experts helping novices to participate by focusing on the relationship between language and learning. It assigns a more direct role for the expert in developing students' learning by providing explicit guidance and hence move from peripheral towards full participation. As Duff (2012, p. 578) notes, 'without explicit socialization … students may invest large amounts of time with relatively little payoff in terms of …success'.

In many of the previous language socialisation studies in healthcare, novices learn the discourses of the profession implicitly from expert others. Parks (2001) and Parks and Maguire (1999) found that Canadian nurses who had completed their nursing education in French learned how to write nursing documents in the style used in English speaking hospitals, mainly by reading notes written by other

nurses. These Francophone nurses were already qualified practitioners and hence had a level of expertise that may have helped them learn implicitly the discourse required in the English-speaking hospitals. In a study of medical residents for whom English was a first language, Hobbs (2004) demonstrated that the residents learned to write progress notes implicitly by reading notes written by more experienced practitioners. Whilst the residents were novices in the medical discourse, they were already expert users of English. However, for EAL novice nursing students who are learners of English, and where much information is new, a more explicit focus on the discourse of nursing may help students participate more effectively (Spafford, Schryer & Creutz 2009).

Important concepts in the expert's role in sociocultural theories of learning that are relevant to my study are, scaffolding, and the zone of proximal development (ZPD). One of the roles for the expert is to guide the learner through the ZPD (Vygotsky 1978). Although there are several interpretations of this zone, it is often referred to as the gap between what a learner can do by themselves and what they can do with the guidance of a more expert other. The ZPD is the space between what students know and can do. It represents their potential learning development. Vygotsky argued that this zone is essential to the development of learning. Movement through this zone is dependent on asymmetry of knowledge mediated through social interaction, and it is this interaction that leads to learning. Thus, learning is a social activity that leads to cognitive development. The learning that occurs in social interactions with others is referred to as intermental and the learning process that develops the individual's cognitive framework as intramental (Vygotsky 1978). In this study, I am focusing on the opportunities created in social interaction to study learning. that is the 'kinds of social engagements that provide the most effective and appropriate context for … learning to take place' (Gibbons 2006, p. 21) rather than focusing on the cognitive processes or concepts. In Vygotsky's terms, this study focuses on the intermental processes rather than the intramental.

Guiding learners through the ZPD is facilitated by scaffolding, a term which has been assigned different meanings by various scholars. Forman (2008) sums up

some of these uses of the term from its initial use to refer to parent child interaction (Wood, Bruner & Ross 1976) to more recent adoptions of the term to describe a more capable person helping somebody learn how to do something so that they can, in the future, do it independently (Gibbons 1999); a form of explicit teaching (Wells 1999); and a form of guidance to give learners explicit information when needed (Cope & Kalantzis 1995). What is common to these definitions is the role of a more experienced person intervening in some way to guide learning. However, as Gibbons (2006, p. 176) states, 'scaffolding is oriented towards showing students *how* to do (or think or say) rather than *what* to do think or say'. Scaffolding has been described as a 'spiraling, cyclical movement that involves both social engagement and separation' (Oxford 2003, p. 86). Eventually, the separation occurs as the activity is handed over to the student. In this way, scaffolding is one way that students might move from legitimate peripheral participation to more full participation. In my study, the focus is on opportunities for scaffolding rather than separation. The unstructured nature of workplace learning and the limited time frame of the clinical placement blocks do not easily allow for longitudinal studies of a learner's individual trajectory in learning to become a nurse.

Studies in nursing and allied health that draw on sociocultural and situated theories of learning have argued that working within the student's ZPD is a model for how experts stage activities to help students engage in peripheral participation, and move from a novice status towards a more expert status (Le Maistre, Boudreau & Paré 2006; Skøien, Vågstøl & Raaheim 2009; Spouse 1998b). However, these studies tend to focus on general descriptions of the activities supervisors engage in rather than the way supervisors use language to help mediate students' learning. Skøien, Vågstøl and Raaheim (2009) argue that skilled supervisors can guide student learning by scaffolding activities that move students along the ZPD. Examples of structured activities that provide scaffolding for learners include expert practitioners talking aloud as they undertake clinical skills to explicitly guide students about what the experts were doing and thinking at the time (Spouse 1998b); practising scenarios with students before an authentic experience; intervening if something happened and the student needed help; and

drawing students' attention to particular features of a case if students had not noticed them (Cope, Cuthbertson, & Stoddart 2000). The skills needed by supervisors are to recognise how much support students need and when they are ready to be given more responsibility and less support. Le Maistre, Boudreau and Paré (2006, p. 347) note that, at first, good supervisors provide a lot of support and constantly assess students' development and 'create opportunities for growth', and gradually reduce that support as students more from the periphery to the centre. Spouse (1998) argues that by engaging in activities that become more complex over time, students develop an identity as a member of the community of practice.

In a study of the supervision of junior doctors in a rural hospital setting, Iedema et al. (2010, p. 288) found that supervision had a 'hands on' component, where supervisor and supervisee were both present in an activity and a 'hands off' component, where supervisees carried out an activity independently and talked about it with the supervisor at another time, or had 'flexible supervisory support when acting independently' (p. 289). Iedema et al. (2010) argue that supervision needs to be flexible to adapt to doctors' needs and that a 'hands on' and 'hands off' model of supervision creates what Lave and Wenger (1991) called a zone of safe learning, as it allows doctors to undertake what they can do with the reassurance that expert help is close by. Although Iedema et al. (2010) do not link the zone of safe learning to Vygotsky's ZPD, there is a similarity in that, it is based on monitoring the doctors' learning and assessing what help they need. However, in this model, it is not just the supervisors evaluating trainees and deciding what scaffolding they need but the trainees themselves playing an active part to monitor their own supervision needs.

This monitoring of student learning is an important feature of scaffolding and may also be important in helping students develop legitimate peripheral participation. Monitoring learning in order to provide adequate scaffolding can also be challenging for facilitators. Providing appropriate guidance can require ongoing attentiveness (Iedema et al. 2010) and facilitators may need to make decisions about when students need support by relying not only on students' clinical skills but also on 'tone of voice, eye contact, facial expression, … physical and emotional

presence, sense of authority and confidence' (Le Maistre, Boudreau & Paré 2006, p. 349). However, as noticed previously, such judgements of EAL students can be fraught with misunderstandings.

What these studies have not shown, is how supervisors use language to work at the leading edge of a student's ZPD. Studies that draw on a range of sociolinguistic theories have drawn attention to the importance of the way supervisors use language to help apprentice novices into the discourses of the relevant community of practice. These studies are reviewed in the next section.

The role of the expert in learning: teaching in clinical settings

Feedback and correction are key roles for clinical facilitators. Several studies in the healthcare field have focused on supervisors' use of correction with medical interns (Pomerantz, Ende & Erickson 1995) and speech pathologists (Ferguson 2010). Pomerantz, Ende and Erickson (1995) analysed interactions between supervisors and medical interns, who are more advanced professionally than undergraduate students. The interns' supervisors mitigated their corrections by using a variety of strategies such as delaying responses or cuing elicitations rather than directly correcting. Supervisors said they corrected in this way as they wanted to build the interns' confidence and did not want to embarrass them. The authors argue that these strategies are a way of maintaining authority in a non-authoritarian manner, which 'lubricate[s] the interaction, easing the face threatening force of unmitigated commands' (Pomerantz, Ende & Erickson 1995, p. 164). They also state that this kind of correction may be a way of ensuring novices move towards more full participation, as mitigated corrections imply the interns can assume more responsibility, whereas explicit corrections may force them to remain on the periphery. Similarly, Ferguson (2010) found that positive judgements about students were expressed directly, whereas negative judgements were expressed implicitly.

Recent research by Eggins (2016) extends the healthcare literature that draws on situated learning and community of practice theories described above (Erickson 1999; Le Maistre, Boudreau & Paré 2006; Skøien, Vågstøl, Raaheim 2009; Spouse

1998a) by providing evidence for the role that language plays in apprenticing students into the discourse of the community (Lave & Wenger 1991). Eggins (2016) describes three different modes of teaching that senior doctors use when teaching junior doctors as part of their daily work. The three modes are: firstly, teaching by (verbal) demonstration, where doctors predominantly modelled clinical activities, for example, reaching a diagnosis, by thinking aloud; secondly, declarative teaching, where senior doctors pointed out significant factors and provided correct information; and finally, teaching by elicitation, where doctors scaffolded junior doctors' thinking by prompting for missing information. Eggins (2016) argues that these three types of teaching interactions help junior doctors become part of the medical community of practice by enabling them to learn the repertoires of the community.

Similarly, recent research carried out in medical general practice settings investigated the learning opportunities doctors provided for students in patient consultations, and the kind of feedback doctors provided to students (Ajjawi, Rees & Monrouxe 2015; Rizan et al. 2014). Similar to the elicitation style interaction identified by Eggins (2016), Rizan et al. (2014) found that some supervisors used strategies to help students self-correct errors by provided indirect feedback through prompting and hinting, rather than correcting. The authors propose that this method of correcting helps preserve students' identities as medical practitioners in front of patients. These studies are particularly relevant to my research and are reviewed in more detail in Chapter 7. However, my study differs in that it focuses on novice nursing students, and in particular novice students who are also English language learners.

The development of professional identities is also key to moving from a novice to a more expert status within a community of practice. Erickson (1999) observed how medical interns were supervised in managing patient cases. The interns carried out a consultation with the patient and then reported back to the supervisor who was in a nearby room. The supervisor and intern then discussed the patient case. Erickson (1999) argues that the supervision session is an opportunity to learn and an encounter where social identities are constructed through language, as the

intern in the study learns to appropriate the voice of a physician. Erickson (1999) argues that the role of the supervisor is partly about modelling behaviour and language so that novices learn to appropriate the voice of experts. However, appropriation by modelling may be easier for students for whom English is a first language than it is for EAL students, who may benefit from more explicit instruction and feedback. None of the above studies that investigated teaching in clinical settings focused on EAL students. It is not clear whether implicit corrections are beneficial when working with EAL students. The challenge may be how to maintain students' confidence and not cause them discomfort, while at the same time provide clear guidance to help them 'appropriate the voice' of nurses.

The role of agency

Iedema et al.'s research (2010), discussed above, highlights the role of students' own agency in learning, in that students monitored their own supervision needs. Billett (2011, p. 28) argues that in order to participate effectively in practice settings, students need to be agentic learners, that is 'active, directed and intentional learners'. However, for novice EAL learners, agency can be complex. As indicated in the previous chapter, facilitators and RNs often expect students to be agentic, as illustrated by their desire for students to show initiative. One aspect of being an agentic learner is being active (Billett 2011). For students in the clinical environment, that could mean asking questions when they do not understand; seeking out information about their patients; and contributing to the end of day debrief sessions. As noted in the previous chapter, students' reluctance to show initiative and a 'willingness to learn' is often attributed to cultural factors and particular styles of learning. However, taking initiative may be difficult because students are in unfamiliar environments, sometimes where expectation are not so clear, and where role relations with facilitators and RNs can be complex. Nevertheless, as discussed in the previous chapter, it seems if students do not display agency, their learning opportunities during clinical placement may be constrained. How facilitators respond to students' sense of agency, or perceived lack of agency, may affect students' opportunities to participate in clinical activities and to be socialised into the language of nursing.

An alternative view to assigning lack of agency to cultural heritage, is to consider the pedagogic choices made by teachers, or in this case, facilitators, Research in second language learning in classrooms by Zarrinabadi (2014) shows that students' sense of agency is affected by the situation and the pedagogic interactions at a micro level. EAL students in Zarrinabadi's study were more willing to communicate if teachers left longer pauses after asking questions, and if they chose topics with which students were familiar (Zarrinabadi 2014). Zarrinabadi's (2014) work builds on seminal work by Rowe (1986) who found that 'wait time', that is the pauses between turns in teacher-student or student-student interactions, influences the level of participation for all students. Rowe noticed that wait time was particularly influential for minority students. To my knowledge, no studies have looked at the wait time used by facilitators when interacting with EAL students in a clinical environment.

Conclusion

This chapter has situated my study within a framework of sociocultural theories of learning, and of second language learning. It has discussed the theoretical frameworks of situated learning, and the concepts of legitimate peripheral participation and community of practice. I have argued that these concepts are relevant to my study in that they provide a useful analytical framework for investigating how novice nursing students access the community of practice (both at the local level of the ward and at the broader level of the profession of nursing) in order to participate legitimately.

The chapter has reviewed previous studies that have drawn on these frameworks to investigate how medical and nursing students learn during clinical settings, and how they learn the discourses of their practice. I have argued that facilitators may play a role in helping students gain access to learning opportunities on the ward. I have also argued that different spaces in the hospital setting may provide access to differing opportunities for learning and for second language socialisation, and that the pedagogic strategies and styles that facilitators use in these spaces may extend or constrain student participation in learning.

This chapter has also noted some of the limitations of theories of situated learning and community of practice that are relevant to my study. These limitations are a dismissal of the role that pedagogy can play in workplace learning; and a lack of theoretical framework that accounts for the role of language both as a tool for learning and as an integral component of the shared repertoire of the community of practice. I have shown how theories of second language socialisation can provide a framework for analysing how novice EAL students gain access to a community of practice, and how expert others can use language to help scaffold students' learning, working within their ZPD. An investigation of workplace learning for EAL students also needs to include an analysis of language at a micro level to investigate how meaning is negotiated within the community of practice, so that students can learn to use the shared repertoire of the community.

This chapter has demonstrated that there is a paucity of research investigating the learning of EAL students in the clinical setting. In particular, there is a lack of research into pedagogic practices that facilitators adopt to help students gain access to the community of practice, and to learn the shared repertoire of the community. My study addresses that gap by investigating how EAL first year nursing students on clinical placement are supervised.

My study builds on previous research carried out with nursing and medical students in clinical settings that draw on sociocultural theories of learning, including the few that have directly addressed the role of language in that learning. It adds to that research by focusing on novice nursing students. It takes an ethnographic approach to investigate the complexities of the daily practices of clinical facilitators and students, who, as noted above, are situated in overlapping communities of practice. My study draws on observations and audio recordings in clinical settings and provides empirical data of interactions between facilitators and students in a range of hospital spaces. Drawing on a range of frameworks for analysing language-in-use, it investigates how meanings are negotiated; how language plays a role in socialising novices into a community of practice; and how the facilitator's pedagogic choices can create or restrict opportunities for students' learning. To my knowledge, this is the first study to draw on audio recordings of

EAL students and their facilitators as they go about their daily routine during their clinical placements.

The next chapter discusses the methodological framework for the study and outlines in detail how the study was undertaken.

Chapter 4 - Researching language and learning in clinical settings

Research approach

As discussed in Chapter 2, the theoretical framework of this thesis views learning and language learning as a social process. In learning to be a nurse, students need to be able to participate in the everyday activities of nursing. Expert others play a role in helping them engage in those activities that guide students in their learning, both physically and through language. Thus, this study was designed to investigate: how students and facilitators –the expert others, interacted in the workplace; the activities and pedagogic practices that create or constrain opportunities for learning; and the role of language in those activities and practices. As noted previously, for EAL students in particular, learning to be a nurse means learning the language of nursing. Therefore, the study was also designed to focus on what opportunities there were for second language socialisation in those practices. Investigating these issues required both a macro analysis of the broader context and a micro analysis of talk in action.

The specific research questions are:

1. Where, when, and why do facilitators and students interact during clinical placements?

2. What pedagogic practices/interactions are in evidence in clinical placement settings?

   2a. What are the focal themes (topics) of these interactions?

   2b. What nursing skills and tasks do students have opportunities to learn in these interactions?

   2c. What professional and institutional discourses do students have opportunities to learn in these interactions?

   2d. What opportunities do facilitators have in these interactions to assess students' clinical skills/tasks and students' use of professional

and institutional discourses

3. To what extent do these pedagogic practices enable and/or constrain students' opportunities to learn about nursing and about the language of nursing?

This research is framed within a social constructivist paradigm whereby language and interaction construct social reality rather than represent it, that is in this research I was not looking for 'facts' or a 'reality … waiting to be discovered in an unproblematic way' (Roberts 2006a, p. 9). Rather, I was investigating how the actions and talk of facilitators and students enacted and constructed these practices. Similarly, I was aware that my role in the research, and my 'insider' position as a language academic who was known to some students and facilitators influenced what I observed, what I chose to focus on in reducing the data, and how I interpreted the data. Taking all of this into account, this research was designed as a qualitative study in the interpretive tradition, exploring a problem and gathering data that are socially situated and context dependent. In this tradition, research is not an objective process in search of a 'truth' but is rather an interpretive process where realities are multiple and constructed (Cohen, Manion & Morrison 2000). In this type of research, the researcher is a research instrument influencing the whole research process from selecting a research problem to interpreting selected data.

It is a multi-site case study with fieldwork carried out in three hospital sites, where students were attending clinical placement. I adopted an ethnographic approach, combined with discourse analysis of audio recorded interactions between clinical facilitators and students. Combining an ethnographic approach with discourse analysis has been successfully employed in previous clinical communication studies investigating the supervision of medical students (Erickson 1999); the communication between patients and emergency department staff (Slade et al. 2011); and intra-professional communication (Iedema 2007) and is an approach that focuses on both macro analysis of context and micro analysis of interactions.

Ethnographic approach

An ethnographic approach was used to gain insights into the complexities of the daily practices of clinical facilitators and students. These insights help provide explanation and context for the discourse analysis of the audio recorded language (Iedema 2007). The importance of ethnographic work in healthcare research has been noted by Roberts and Sarangi (2003 p. 342) who highlight the challenge of discourse analysts entering the world of medical professionals where the analysts (the researchers) usually lack medical knowledge. They argue that gaining insights into the medical world is best achieved by 'hanging around with doctors in a range of real life settings' (p.342). By 'hanging around' with facilitators and students, I was hoping to gain insights into the complexities of the daily practices of clinical placement in a world that was largely unfamiliar to me. Furthermore, as I intended the outcomes of my research to be of practical use to clinical facilitators and students, I needed to understand 'the real world' (Roberts & Sarangi 2003, p. 341) of clinical placements.

The study is not a full ethnography, as it did not seek to explore all aspects of students' clinical placement experience. Instead, it focused on one aspect of their experience of clinical placement, that is, their interactions with facilitators. This type of ethnography has been termed an 'ethnographic approach' (Street 2012, p. 39), whereby an 'ethnographic perspective is systematically applied to specific situations and processes'.

Although not a full ethnography, the purpose of the ethnographic approach is similar to that of other ethnographies, that is, to study 'social interactions, behaviours, and perceptions that occur within groups, teams, organisations, and communities' (Reeves, Kuper & Hodges 2008, p. 512). The ethnographic approach used in my study is underpinned by key characteristics of ethnographic work as outlined by Hammersley and Atkinson (2007): it is naturalistic; data were collected from a range of sources, including informal conversations with participants; the data collection did not follow a predetermined framework; data analysis is qualitative; and the number of cases studied are small. However, whereas Hammersley and Atkinson include participant observation as a

characteristic, I was predominantly in a non-participant observation role. Furthermore, the clinical placement blocks were bounded in time (Creswell 2007) in that each placement lasted for two weeks, restricting the amount of time I could spend in the field.

Discourse analysis

I am using the term discourse in its broadest sense to refer to language in use, that is 'language used to do something and mean something, language produced and interpreted in a real-world context' (Cameron 2001, p. 13)**.** Mainly, I focus on spoken discourse, although Chapter 9 looks at the role of facilitators' talk in helping students understand written nursing notes. The approach to discourse analysis is situated broadly within sociolinguistics, drawing on interactional sociolinguistics (Gumperz 1999) and the ethnography of communication (Hymes 1974). The language analysis focused particularly on opportunities students had to participate in interactions with facilitators, patients and students; and pedagogic strategies that facilitators adopted in interacting with students.

Rather than beginning with an analytical framework to analyse language at a micro level, I began with the ethnographic analysis from fieldwork and chose audio recordings that were typical of the activities created from the ethnographic data analysis. This is in line with an interactional sociolinguistic framework where workplace studies begin with an initial ethnography and then based on the overall analysis of the setting, researchers choose what to record (Gumperz 1999). However, due to the constraints of the two-week block, I was not able to carry out initial fieldwork and then choose what to record. Rather, I chose to record from the second day, and to record whenever possible. I then selected which recordings to use after ethnographic analysis of field notes. After transcribing recordings, I developed analytical frameworks to tease out 'what was going on' (Goffman 1974). In this way, the recorded data are part of the 'larger text' (Hak 1999, p. 447). Hak (1999, p. 447) sums up this approach as an 'ethnography in which conversation and discourse analytic techniques are integrated in, and made subservient to ethnographic fieldwork'. As my focus is on EAL students' learning, and the opportunities and constraints for second language socialisation, ethnographic

analysis focused particularly on talk between students and facilitators, that is where, when and how talk occurred, or did not occur, between facilitators and students (Gumperz 1999). The frameworks drawn on for discourse analysis include a 'theme oriented' approach to discourse analysis developed by Roberts and Sarangi (2005) and Sarangi (2010); frame analysis (Goffman 1974); the SPEAKING grid from the ethnography of communication (Hymes 1972); and exchange structure in classroom teaching (Sinclair & Coulthard 1975) and similar work on classroom interaction by Mehan (1979). These are described in more detail below when discussing how data were analysed.

Validity

Creswell (2007) argues that in qualitative research, validation is strengthened by ensuring accuracy of data. He proposes strategies that strengthen validation including prolonged engagement and observation in the field, building trust and learning the culture of the research site, triangulation, and clarifying researcher bias. In my study, the ethnographic approach and spending the whole two-week block placement with participants enabled me to become familiar with the culture of facilitation in the hospital setting and to build trust with participants. Similar to Liu, Manias and Gerdtz's (2012) hospital based study, my study has multiple levels of triangulation. These are:

- multiple data sources (field notes, interviews, audio recordings, documents)
- space: three different settings
- time: two morning and one afternoon shift.

It also has multiple methods of analysis (ethnographic and discourse analytic). The rich descriptions of my research based on the multiple sites, participants and approaches to interpreting data also mean that readers can decide whether these findings are transferable to other settings (Creswell 2007). The phenomenon of the observer's paradox (Labov 1972) has been well documented. During fieldwork, I attempted to mitigate my effect on participants' behaviour by spending extensive time with them to accustom them to my presence; and by not recording in sensitive situations (when students seemed distressed). Nevertheless, it is likely

that participants were affected by my presence.

Creswell (2007) also notes that a further criterion of good qualitative research is catalytic validity (drawing on Lather 1991), that is, whether the research results in bringing about change. Lather (1991) was referring to changes in the lives of the participants and arguing for participatory models of research. Given the short time in the field and the complexity of gaining access to the sites and participants, a participatory approach to my research was not feasible. Nevertheless, the validity of this research may be gauged according to its uptake by nursing academics and educators. Whilst completing this PhD, I have continued in my professional role as a language educator working with both students and academics in a Faculty of Health. I have drawn on my research to present professional development workshops to facilitators, clinical preparation programmes to students, and to develop online video resources for students replicating some of the activities I observed during the placements. These early practical initiatives drawn from this study provide some indication of the catalytic validity of the research.

My role

I have worked closely with the university health faculty associated with the research sites for approximately 15 years in a consulting and teaching role on matters relating to language and literacy. This role influenced the research. Researching one's own workplace can be problematic. However, it can also offer advantages. In my research, my professional reputation facilitated my entry to the workplace as I already had the trust of some of the key 'gatekeepers', that is faculty staff who were responsible for clinical placements and whose support was essential in enabling me to gain access to clinical sites.

Allen (2010) discusses the insider outside roles of researchers in healthcare settings. She argues that an insider role is useful if it helps develop relationship with research participants to get an authentic account but there is also a danger of being desensitised to the setting. My role as an insider was not to the healthcare setting itself but rather in my relationship with students and facilitators and my position as a language educator in nursing within the institution to which

facilitators and students belonged. The insider role worked on two levels, that is, prior to fieldwork beginning and actually during fieldwork. An insider role was essential to my being able to organise this study as I knew the key people with whom I needed to liaise and whose knowledge I could draw on to manage the logistics of the project (see section below 'gaining access to the site'). There was a possibility that students might feel embarrassed at having another person observing them. However, my insider role as a teacher who had previously taught students in a programme that helped them prepare for clinical placement meant that students generally saw me as a 'helpful resource'. I reinforced this role by explaining to students that I was willing to listen to any problems they wanted to discuss with me, and would advise them about useful language resources and university contacts if they were having problems. However, I also explained that I would not act as an intermediary between student and facilitator. I also explained clearly to students at the beginning of each placement that I was not assessing them; reassured them that anything they said would remain de-identified; and offered them a choice not to be audio recorded. Any discussion I had with students formed part of the data.

My experience as a language educator with nursing students influenced what I noticed during the clinical placement. I was aware that in my observation, I focused keenly on whether I thought students were understanding facilitator talk; observed how often students joined in that talk; watched students interact with patients and observed whether they used the kind of communication I had taught in clinical language programmes as part of my professional role at the university; and made my own assessments of what I thought about students' levels of English language performance. I also watched how facilitators taught and compared it to the way I viewed my own pedagogic practices; I noticed how quickly or how slowly they spoke; how they talked about students; how they made assessments about students and whether I would have made the same assessments. All of these reflections were documented in my field notes.

My outsider role in this research was mainly to the hospital system, having spent little time in hospitals prior to my research. This lack of experience enabled me to

understand students' experience as newcomers to the clinical environment, which made me aware of challenges they faced in integrating into a workplace. Healthcare staff and two of the facilitators also seemed to see me as an outsider and frequently commented on my role as a learner in the hospital setting, suggesting that I must be learning a great deal. I agreed. Glenda in Red Hospital tended to view me more as a resource based on my expertise as a language educator. On several occasions, Glenda asked me directly for feedback, what Clarke (2003, p. 383) referred to as 'hot' feedback where professionals who are being observed received feedback on interactional processes that the observer has noticed. For Clarke, a medical practitioner, this feedback is one of the benefits of participating in research. In my case I only offered hot feedback when asked. For example, we had several conversations about students when Glenda was not sure if they understood her, or whether she was speaking at an appropriate pace. I was aware that the type of feedback I gave could impact on students' outcomes. In the initial discussions with facilitators, I had clarified that I was happy to talk about the decisions facilitators were making about students in term of assessments, but would not make any recommendations about those assessments. I was not asked by facilitators during the research to make comments on students' English language performance. Discussions I had with facilitators also became part of the data and were included in the analysis of my field notes.

Although advantageous in organising the logistics of the study, and in developing relationships with students and facilitators, my insider status also posed several ethical challenges. As both facilitators and students knew me as an academic who worked with the university, they may have felt a sense of obligation to participate. I designed a recruitment process that aimed to minimise this sense of obligation. The process I used to recruit students ensured that I was not present when students and facilitators consented to the research. They were invited to opt in to the study if they were interested. All other ethical processes were addressed and approval was received from all the relevant bodies to proceed with the study. Information sheets that were provided to students, clinical facilitators, patients and hospital staff are included in the appendices.

Research design

Research sites

The use of multiple sites allowed for individual and cross-site analysis, in order to gain a broader and deeper understanding of students' and facilitators' experiences of clinical placement. The choice of three sites was also influenced by pragmatic considerations; as clinical placements occur at set times of the year, it was only possible to attend three two week block placements within that timeframe. As I wanted to study which pedagogic practices enabled or constrained novice EAL students' opportunities for learning during clinical placement I chose to observe first year students – the most novice students. I observed first year students who were on their second clinical placement for their undergraduate degree, as the first clinical placement is only one week long and students are mainly in an observational role. The second clinical placement occurs towards the end of their first year of study, is a two-week block placement and students are expected to participate in nursing practices on the ward. This placement is also seen as a gateway to their second year. Students need to pass the placement, in order to progress to the second year of their degree, by showing ability in a range of clinical skills. At the time of my study, the second placement was also the first time a facilitator would assess whether their level of English language proficiency was adequate for the placement.

Each clinical placement was located in a different hospital, had a different facilitator, and a different group of students. The hospital sites were determined according to the allocation by the university of students and facilitators who had previously agreed to participate in the study (the recruitment of participants and organisation of the study is described in more detail below).

Gaining access to the workplaces and selecting participants

Organising participation in this study was a complex process. Challenges of gaining access to workplaces generally (Roberts 2010) and clinical placements, in particular, have been noted in previous studies (Duff, Wong & Early 2002; Eyre 2010; Spouse 1997). Some of these challenges include gaining permission from

clinical sites to observe students and patients; organising fieldwork in accordance with the transient nature of clinical placements; and the time required to negotiate with multiple stakeholders including clinical managers. As a result, in some studies, researchers who initially intended to include fieldwork, adapted their approaches to include interview data only (Duff, Wong & Early 2002; Eyre 2010) or brief visits to clinical sites (Spouse 1997). I used my position as an insider of a university to liaise with faculty and clinical administrators to determine the best way to gain access to sites and participants. Permission needed to be granted from the area health authority, the areas governing the individual hospital sites, the individual hospitals, the nurse unit managers of the wards where students were located, the university, and from students and facilitators.

One of the logistical challenges was that permission needed to be granted by all of the above prior to students being allocated to clinical placement sites by the university. As a result, I gained permission from the largest hospitals that would be likely to take the greatest numbers of students; I gained permission from as many students as possible (EAL and non EAL) and from as many facilitators as possible. In the consent form I asked students to indicate whether they spoke English as an additional language. I also offered a choice for full participation, which was observation and audio recording or partial participation, which was observation only. The choice about audio recording was to cater for students who might be concerned about being recorded, particularly if they were worried about their English language ability. This information was sorted and collated into four excel spreadsheets.

1. EAL student who had given full consent (62)
2. EAL students who had given partial consent (60)
3. Native speaker students who had given full consent (84)
4. Native speaker students who had given partial consent (31)

I then liaised with the university clinical placement unit who agreed to allocate at least two students from list [1] to each of the three hospital sites where I also had permission to observe. This allocation was only completed approximately one or

two months prior to fieldwork beginning. The unit then allocated facilitators who had consented to the research to the groups that I would observe.

Meanwhile, I contacted each hospital and the nurse unit managers of each ward where students were placed to confirm their agreement to my observing on their wards (this was part of the ethics approval process). The complexity of this process may explain the dearth of situated research in the area of student clinical placements.

Initially I had intended to use purposive sampling, that is, choosing participants for a specific purpose, (Cohen, Manion & Morrison 2000) to select facilitators. I intended to observe experienced facilitators who had a reputation for working well with EAL students. However, this was not feasible due to the complex nature rostering facilitators' shifts.

Data Collection

Multiple data were collected, as summarised in Table 1 below.

Table 1: Data collection

Participants	Three clinical facilitators Three groups of 1st year nursing students (7 or 8 students per group; 3 or 4 EAL students in each group)
Sites	Three hospital sites: Green Hospital, Red Hospital, and Blue Hospital
Observations	Green Hospital: 75 hours Red Hospital: 80 hours Blue Hospital: 75 hours
Field notes	From each site –unstructured: included observations and my reflections
Audio recordings	Green Hospital (approximately 6 hours) Red Hospital (approximately 22 hours) Blue Hospital (approximately 18 hours) *the variation in hours recorded is indicative as to how much time students and facilitators spent where recording could occur- that is away from patients and other healthcare staff
Interviews	Facilitators x 3 Students x 10

Description of three hospitals

The study was carried out in three large urban hospitals in Australia. The hospitals are referred to as Red, Blue and Green Hospitals. The hospitals were major teaching hospitals, situated close to city centres. All had linguistically diverse patients and staff. All had multiple specialty wards. All hospitals regularly hosted large numbers of students who were undertaking clinical placements.

Participants: facilitators

Names used for all participants are pseudonyms. Some participants chose their own pseudonyms, others asked me to choose for them.

Three facilitators were shadowed, one in each hospital. Table 2 below shows the number of years of experience that each facilitator had in supervising students and their language background. As illustrated in Table 2, the facilitators had ranged from minimal to extensive amounts of experience as facilitators. However, Kim, who had the least amount of experience, also had extensive experience as a nurse educator in the clinical setting. Kim was also the only facilitator who had been born overseas and experienced migrating to a country at a young age. However, unlike the EAL students in this study, English was her first language.

Table 2: Facilitators in the study

Facilitator	Hospital	No. of years facilitating	Language background
Kim	Green	less than two	English (but born overseas)
Glenda	Red	more than 20	English
Mel	Blue	more than 5	English

Participants: students

I observed a total of 21 students, 16 of whom were EAL students. Whilst I observed all students, I focused particularly on the EAL students. The participants included both female and male; local students who spoke English as a first language and local students who spoke English as an additional language; international students, all of whom spoke English as an additional language (although three students were from countries where they had frequently spoken English -India and Nepal); and a range of ages. Some students had just finished high school, while some were in

their thirties. Appendix 1 summarises the students' status as international or domestic students, their country of birth, gender, relevant work experience and previous education in Australia. In this section, I only describe briefly some of the students who are mentioned by name in this study to provide an overview of the depth and breadth of experience that students brought to the clinical placement.

Mingxia, a student originally from China, was already an overseas qualified RN and had worked extensively as an RN in China and the Middle East. She had chosen to undertake a three-year nursing degree, as she did not think she would be able to attain the necessary English language assessment scores required to undertake an accelerated programme to qualify to work as a nurse in Australia. Some students had gained degrees overseas in different disciplines. One of these students, Hua, was a qualified welfare worker in Taiwan and had worked for women's rights. Ryoko, from Japan, had worked in a large corporate company in her home country; Angie, from Indonesia, had completed an accounting degree overseas. Many of the students, had also undertaken courses in Australia either in English language, or diplomas in subjects other than nursing that were taught in the English language. Some students, for example, Mouy, originally from Cambodia, had lived for some time in Australia but stated that they had few opportunities to speak English outside university and clinical placement. One student for whom English is first language, Sam, is mentioned by name in this research, as I analyse an interaction with him and an EAL student (see Chapter 10). He was a recent school leaver. Further details about students are provided throughout the thesis when relevant.

The details of the students' lives were not the focus of this research. However, the rich diversity amongst this group of students reflects that which I have seen in my own experience as a teacher, and which has been noted in other studies (e.g. Dickson 2013). It illustrates the limitations of terminology when referring to this diverse body of students as 'international students' or 'EAL students'.

Fieldwork

As the aim of this research was to investigate how facilitators interacted with students, I shadowed the facilitators in each hospital as they went about their daily

practices of supervising students. I met facilitators at the beginning of the shift and remained with them each day until the end of the shift. Two of the placements were morning shifts (7.00am-3.00pm) and one was an afternoon shift (2.00-10.00pm). Occasionally, during the day, I had lunch or coffee separately from the facilitators but for the majority of the shift, we spent time together. Alongside the facilitator, I attended clinical handovers, observed students perform patient care, and watched students as they walked about the ward. I observed as facilitators spent time individually with students following up on activities they had observed, reading patient documents and providing formative and summative assessments. I also observed end of day debriefing sessions when the facilitator met with the whole group of students. At times the facilitator and I chatted socially with students in tea rooms or canteens as they were on their breaks. Occasionally, I talked alone with students if the facilitator had to attend to something that was not appropriate for me to observe, for example, helping a student shower a patient. I also spent time alone with the facilitator as we walked between wards, or took meal breaks together. Fieldwork was thus a combination of observations and informal talk with facilitators and students which allowed me to develop a thick description (Geertz 1973) of what occurred during clinical placements.

Field notes

I took field notes during these observations, using a handwritten notepad and clipboard. I did not follow a predetermined system but I generally noted where interactions occurred, who was present, and what happened during interactions. I also drew sketches in my field notes. These initial sketches were used as a resource to draw the sketches that appear in this thesis. When watching students interact with patients, it was not possible to audio record (I did not have ethics approval for recording patients) and so, where possible, wrote down verbatim what students said. I also noted my reflections on those observations and on my interactions with participants. These early reflections were the beginning of the process of analysing the data as I began to note things I found typical or unusual. For example, I noted early on that space seemed to appear frequently in my notes. I also observed differences between the pedagogic styles of facilitators within the first few placements and noted these as 'asking' and 'telling'. At the end of each

day, I added further notes summarising my reflections for the day. Field notes were extensive and detailed (see Table 3 below for word count of field notes). I handwrote each day and at the end of the week I transcribed my notes into a word document.

Table 3: Summary of field notes

Hospital	Number of words of field notes
Green	46,536
Red	42,109
Blue	36,075

Audio recording

Where possible I audio recorded interactions on a small digital recorder. Audio rather than video recording was chosen to reduce the sense of intrusion and potential stress for students who often feel anxious during clinical placement. I also only audio recorded when not in the presence of patients and other health care professionals in order to minimise my intrusion. Audio recorded interactions included individual sessions between facilitators and students in various locations including tea rooms, corridors, nurses' desks, meeting rooms, pan rooms and patient lounges. I also recorded sessions where all students met with facilitators: these were the end of day debriefs. I occasionally recorded conversations that I had with students and facilitators throughout fieldwork. These were additional to interviews I carried out.

Some audio recordings were difficult to hear clearly, due to background noise, for example, trolleys carrying equipment, medicine or meals rattling down the corridors, and the constant beeping of machines and patient buzzers. At other times, I chose not to record as I felt it would cause additional stress for students, for example, when talking about things that had gone wrong.

Documents

I also had access to university guidelines for clinical facilitators, documents that outlined information for students about clinical placements. These documents were mainly used as background knowledge prior to fieldwork to gain an

understanding of university expectations of facilitators and students. For those students I interviewed, I also received copies of clinical assessment forms which documented the facilitators' comments on student's performance and students' reflections on the placement. Again, clinical assessment forms were used mainly as a resource to identify skills that students were expected to perform during the placement.

Interviews with facilitators

The interviews with facilitators were held in the last two days of placement. While I had chatted to facilitators throughout the placement, the interviews differed in that they were approximately a half hour discussion, focused mainly on the topic of English language. They were held in the hospitals; one was in the tea room; one in the hospital canteen; and one in a quiet nook in a corridor. The interviews were semi-structured and the following prompts were used to guide the conversation.

1. What was your overall experience of the clinical placement I observed – the good points and the bad points?
2. How did you find the experience of supervising EAL students?
3. What did you notice about students' use of English language?

Interviews with students

All EAL students were invited to interviews after the clinical placement. Eleven students agreed to participate. Table 4 (below) shows the number and gender of each student who participated from each research site.

Table 4: Student interviews

Hospital	**No of students interviewed**
Green	Four (female)
Red	Four (female)
Blue	Three (two females; one male)

The interviews were semi-structured and students were sent questions prior to the interview so that they had time to consider their responses. However, the questions were used as prompts and the interviews unfolded according to participants' responses.

1. What was your overall experience of clinical placement?
2. Can you tell me about your experiences of using English language during clinical placement?
3. What kind of things did you learn on clinical placement?
4. What, if anything, do you think helped you learn on clinical placement?
5. What, if anything, made it difficult for you to learn on clinical placement?
6. If you were the 'boss', running the clinical placements, would you make any changes?
7. Is there anything else you would like to tell me about your clinical experience?

Data analysis

Data were analysed using multiple methods. Field notes, and participant interviews were analysed reiteratively, returning to my research questions and drawing on my own expertise as a language educator within nursing. As noted above, my role in the analysis and interpretation of data was what Srivastava and Hopwood (2009, p. 77) refer to as a 'deeply reflexive process'. I began with field notes of Green Hospital and analysed them for key themes. I then listened to and transcribed student and facilitator interviews and analysed those for key themes. I repeated the process with the other two hospitals. I revisited the data from multiple angles, noting participants, activities and locations. In this way, I was 'analysing the local communicative *ecology*, exploring not only the persons but their recurrent encounters, the critical observings of "goings on", interviewing of key players, focusing on selected events' (Candlin 2000, p. 7).

My analysis of field notes was then mapped into excel spreadsheets. The framework for the spreadsheets is illustrated in Appendix 2. I used this framework to identify for each interaction:

- the place and location

- the participants
- the activity
- the focus of the activity
- the manner in which the facilitator and students interacted (for example, asking questions, using equipment)
- points related to language, for example the use of specialised terminology
- the number of the audio recording

Tracking and mapping data in this way enabled me to make sense out of a large amount of data and to see emerging patterns. It was an approach that allowed me to reduce data carefully and systematically. Finally, I chose to organise data according to the spaces where activities took place and the activities within those spaces. I then listened to audio recordings multiple times and mapped the audio recordings to the activities on the spreadsheets. This was the first stage of data analysis. The thematic overview of my field notes and the interviews is presented in Chapter 5. The analysis of field notes and interviews in this way gave me a thick description and helped me identify participants' perspectives and what seemed to be important 'sites' of learning (Candlin 2000, p. 9).

This thick description provided the context for the interactions analysed at a micro level. I listened to audio recordings and reread field notes from each space in order to further analyse the activities within those spaces. I then selected audio recordings that were typical of these activities, and that were also of a good enough quality to transcribe (some recordings were difficult to transcribe due to background noise as described above). When no audio recordings were available for activities, particularly those in the patient room, I reconstructed dialogue from my field notes (Stoller & Olkes 2013), using verbatim quotations when available and paraphrasing when I had not written down exactly what participants had said.

I then developed a framework to analyse the audio recordings systematically, drawing on a number of approaches to discourse analysis. This analysis was informed by the key themes of the ethnographic research. Questions I asked as I analysed data were:

- What was ‘going on’ in the activity?
- What nursing skills and knowledge were focused on?
- What pedagogic strategies did the facilitator use?
- To what extent did students participate?

The framework I used for analysing interactions is broadly situated within sociolinguistics. It draws on a ‘theme oriented’ approach to discourse analysis developed by Roberts and Sarangi (2005) and Sarangi (2010). The analysis begins with the activity type drawing on Levinson (1979). Activity type is a goal-defined event like a job interview. Sarangi argues that healthcare encounters are activity types with inferential schemata, that is, people interpret what is to be said and what people mean according to how they understand the activity type. Thematic discourse analysis focuses on ‘focal themes’ and ‘analytical themes’. Focal themes are topic related, for example autonomy, responsibility, and neutrality. Analytical themes focus on how the interaction occurs (Roberts & Sarangi 2005). In my research, whilst some of the activity types of professional activities have been researched, for example, giving clinical handovers (Eggins & Slade 2012) and undertaking patient care (Holmes & Major 2003; Major & Holmes 2008), little is known about the pedagogic activities that facilitators use to help students participate in nursing activities on the ward. This framework offers a way of analysing what facilitators chose to focus on (the focal themes) and how they interact with students in ways that extend or constrain learning of those focal themes. It also focuses on the opportunities these activities provide for second language socialisation.

As noted above, I drew on Goffman’s (1974) frame analysis to work out ‘what was going on’ in each activity. Frame analysis was useful in that it allowed me to categorise activities according to two broad frames, ‘education’ and ‘workplace’, and then create more frames within these two broad frames; for example, within the workplace frame there is a ’patient care’ frame and a ‘daily work practices’ frame. Drew and Heritage (1992, p. 8) summarise frame as ‘the definition which participants give to their current social activity – to what is going on, what the situation is, and the roles which the interactants adopt within it’. As Goffman

(1974) notes, participants may have different views of what is going on and there may also be different things happening at any one time. In the clinical setting, where the education role has to fit in with the workplaces practices, this notion of different frames is particularly pertinent.

Whilst employing the theme oriented discourse approach, I extended the analytical framework by also drawing on an ethnography of communication model, commonly referred to as the SPEAKING model (Hymes 1972) as a heuristic (as proposed by Schiffrin 1994) to systematically describe the activities and interactions. Ethnography of communication originated in the field of anthropology and has been used to investigate the rules of speaking in particular cultural contexts. It aligns with the ethnographic approach and the focus on activities adopted in my study as it attends to 'the interdependence of language-using and other activities' (Cameron 2001, p. 53). As the ethnographic approach of my thesis is particularly focused on language, the SPEAKING framework from the ethnography of communication provides a systematic way of analysing how language was used in particular activities and spaces within the clinical settings. This framework was useful for exploring the ethnographic aspects of the activity; where and how it occurred; who participated; and what the goal of the activity seemed to be.

My approach to analysing data at a micro level drew on a range of tools from different theoretical backgrounds. The analytic themes I used drew on those proposed by Roberts and Sarangi (2005) and include frames (as described above) and footing (Goffman 1981), which Roberts and Sarangi (2005) note is a way of analysing how the roles and relationships of participants can change (for example, in my study from that of a nurse to a student); face and facework (drawing on Brown & Levinson 1987) in particular, politeness strategies to analyse how direct or indirect instructions are given. In order to analyse the pedagogic aspect of the interactions I used tools from structural functional approaches to discourse analysis used by the Birmingham School (Sinclair & Coulthard 1975) and tools from classroom research by Mehan (1979). These approaches focused on analysing exchange structure frameworks in classrooms. An exchange structure is

composed of a set of moves that form a particular function. The exchange structure I draw on is the initiation, response, feedback (Sinclair & Coulthard 1975) or (initiation, response, evaluation pattern) (Mehan 1979) that were found to be typical interactional patterns in classrooms where teachers initiated interaction, students responded and teachers evaluated or followed up by prompting for more information or elaborated on the topic. However rather than feedback or evaluation, I adopt the term 'follow up' (Sinclair & Brazil 1982) to capture the multifunctional nature of the 'F' move in my data. The initiation, response, follow up (IRF) pattern has been widely used in educational research to study pedagogic interactions. The IRF pattern was drawn on to analyse the pedagogic strategies of facilitators at a micro level.

As reviewed in Chapter 2, many EAL students have difficulties in using specialised terminology and in switching register (for example, moving from using medical and nursing language to using everyday language and vice versa). Therefore, although not central to the overall analysis, I paid attention to corrections made by facilitators that focused on terminology and/or register. I also noted lexis with which students were unfamiliar.

Designing a framework for analysing discourse

The Hymes SPEAKING grid was reorganised to group together factors that related to each other: Rather than speech event as in Hymes (1972), I use the term activity (Roberts & Sarangi 2005) to capture the idea that often there was physical action as well as spoken language and at times the physical action was prioritised. Other aspects drawn from frame analysis and exchange structure were incorporated into the framework, illustrated in Figure 1 below. As mentioned above, I used the framework as a heuristic to guide my analysis. After analysing each activity at an ethnographic and discourse level, I asked a series of analytical questions, to further interpret the analysis and answer my research questions. This approach is similar to that illustrated in Stubbe (2010). These questions are also illustrated in Figure 1.

Activity	• What is the activity?
Setting: where located in time and space	• The physical environment; (what it is usually used for and how it is repurposed • The relational aspect of space (who the space 'belongs to') • How students gain access to the space
Frame	• 'What is going on here?' (education; patient care; daily work practices)
Ends	• What is the goal of the activity?
Genre	• Does it belong to a recognised 'type' e.g. clinical handover?
Participants	• Who takes part and what role?
Instrumentalities	• What channels are used – speaking writing; computer screens; phones; physical equipment e.g. stethoscope tools?
Norms: what rules are there	• Who speaks? • Turn taking; who initiates; who stays silent?
Act sequence: what speech acts make up the activity	• What exchange structure is used – IRE/F? • What pedagogic style is used? ('asking' or 'telling' from field notes).
Key	• What tone is used? (e.g. joking, serious, admonishing)

Analytic questions asked based on above framework

- What opportunities does the activity provide for students to learn about nursing?
- What opportunities does the activity provide for students to be socialised into the language of nursing?
- What are the key discourses into which students get socialised in the activity and what role does nursing terminology and/or register play in this socialisation?
- What opportunities does the activity provide for facilitators to learn about students' performance (including English language)?
- What if anything seems particular to EAL learners?

Figure 1: Framework used for analysing discourse

Transcription

Transcription is part of the analytical process to gain better insights into the interactional patterns in the recordings. It allows the researcher to systematically

pay attention to details in the interaction in a way that listening to audio recordings does not (Cameron 2001). It is, however also a presentation of empirical evidence and it is important to balance accuracy and detail with clarity and readability (Cameron 2001). The outcomes of the thesis are intended for an audience of nurse educators and academics, rather than applied linguists. I chose therefore to make transcripts readable for that audience. Details noted in the transcript focus on turn taking, silences, overlaps and intonation which indicate turn taking patterns. I also noted emphasis to demonstrate what speakers chose to highlight. In other areas, I foregrounded readability rather than accuracy, in particular, when transcribing words that students were trying to pronounce. Rather than transcribe them with the International Phonetic Alphabet (IPA), I transcribed them in standard spelling and noted in additional information that the student was trying to pronounce the word. My focus was not on the sounds the students were making (which would require IPA transcription) but rather how facilitators responded to these attempts at pronunciation. A second area where I chose to use standard spelling was when participants mispronounced words. When the speaker's meaning was clear to the listener, I transcribed mispronunciations in standard spelling. There were two reasons for this decision: my focus was not on students' ability to pronounce words, it was on the negotiation of meaning between participants; secondly, I did not want to stigmatise students (Roberts 1997) by presenting their speech in non-standard spelling, particularly as this was not the focus of analysis.

Transcription conventions were adapted from Roberts (2006b) and Forman (2005) to capture details that were significant to interpreting how participants jointly constructed the interaction.

Table 5: Transcription conventions

(.)	Pause of less than 1 second
(2)	Pause indicating time in seconds
[	Overlapping talk where utterances start and/or end simultaneously
]	
-	(dash) speaker breaks off
//	Latching – when one turn follows another without a pause
[*Ryoko writes in chart*]	Additional information
(*unclear*)	Unclear speech
.	Falling tone
?	Rising tone
!	Rising/falling intensity, animation
(,)	Mid rising tone – often when recounting a list of terms
((yes))	Backchannel comments in longer stretches of talk where the listener is making comments indicating they are listening
CONSTRICTED	Capital letters show emphasis

Conclusion

This chapter has outlined the methodological framework for this study. It has provided details on the methods, the participants and the research sites. The study is a qualitative study that uses an ethnographic approach combined with discourse analysis to investigate the daily practices of clinical facilitators and students at three clinical sites. The analysis draws on a range of frameworks, including the ethnography of communication, frame analysis, and a theme oriented approach to discourse analysis, in order to systematically analyse the interactions between facilitators and students and to ground them in the context of the hospital setting.

The following chapters present the key findings of this research.

Chapter 5 - Overview of key findings

This chapter presents an overview of the key findings based on a thematic analysis of interviews with students and facilitators, and of my field notes. It considers what EAL students learn during placement, how they gain opportunities to learn, and what hinders their learning. The final section of this chapter considers how three themes interact to influence opportunities for learning in the clinical setting: these themes are space, the facilitator's approach to facilitation and the facilitator's pedagogic style. This overview sets the scene for the following chapters.

Students' perspectives

The interviews were analysed for themes. These themes were then analysed and grouped into larger categories. There were four categories: **learning opportunities**; **access to learning**; **challenges to learning**; and **student agency**. The first category relates to *what* students had opportunities to learn and the other categories relate to factors that affected their access and engagement in that learning. Some themes were also associated with particular topics. The categories, themes, and topics are summarised in Table 6 below. During interviews, students commented that they learned from nurses, patients, students and their facilitators. Here, I mainly discuss findings related to facilitators, as this is the focus of this study.

Table 6: Themes from student interviews

CATEGORY	THEME	TOPICS	
Learning opportunities	*Becoming a nurse*	Correct procedures	
		Clinical skills and tasks	
		Specialised language of nursing	
		Thinking like a nurse: planning and prioritising	
		Thinking critically about patient care	
	Being a student	Rules and regulations	
		Scope of practice	
		It is okay to make small mistakes	
Access to learning	*Pedagogic practices*	Time management and organisation of day	
		Teaching style	Asking questions
			Listening
			Slow pace of talk
			Talk time for students
	Relationship with facilitator		
Challenges to learning	*Pedagogic practices*	Time management and organisation of day	
		Teaching style	Telling: too much information
			Fast pace of talk
			Limited talk time for students
	Confusion about expectations		
	English language performance		
	Power relations: Facilitator and buddy RN		
Student agency	*'Grabbing opportunities'*		
	Wanting direction		

Learning opportunities

The two themes in this category were *becoming a nurse* and *being a student*. *Becoming a nurse* incorporated how the clinical facilitator helped students learn clinical skills and tasks. Examples include showering patients, documenting care, reading notes and charts, and giving a handover. *Becoming a nurse* also included learning the specialised language of nursing, that is, medical terminology and abbreviations and the particular ways of structuring certain types of discourse like handover. Learning terminology included knowing how to use 'other words' if students were not sure of the medical terminology. Students also learned to think like a nurse in terms of planning and prioritsing care, as well as thinking critically and clinically about patient care. Rather than just completing clinical tasks, some students felt their facilitators helped them to think critically about what they were doing and why they were doing it. Above all, students felt they were learning the correct procedures from their facilitators, which might involve critiquing practices they saw other health professionals undertaking.

A second theme in this category was *being a student*. Students learned that they did not need to know everything and that they could make small mistakes.
They also learned about the rules and regulations regarding students' scope of practice and the level of supervision required from their buddy RNs. The scope of practice refers to clinical tasks that students were allowed to do independently or with the support of the buddy RN, according to their stage of learning. For example, during this placement, taking blood pressure was within students' scope of practice but administering medication was outside their scope of practice. None of the students talked about learning how to communicate therapeutically or otherwise with patients. In contrast, some students talked about how they had learned how to talk to patients in difficult situations by observing their buddy RNs; for example, Soo-jin talked about observing her buddy talking to patients who were receiving end of life care.

Access to learning

Things that helped provide students **access to learning** opportunities were the *pedagogic practices* adopted by facilitators and students' *relationship with the*

facilitator. *Pedagogic practices* included two topics: the overall approach the facilitator adopted to facilitation in terms of time management and organisation of the day, and the style they adopted in interacting with students. For example, students in Blue and Red Hospital appreciated having a daily debrief session at the end of the day. Several students appreciated that their facilitator spoke slowly and explained things clearly. In particular, Hua, Ryoko and Soo-jin from Red Hospital commented on the style of teaching of their facilitator. They felt that she encouraged students to talk; was a good listener; spoke slowly and took time when doing activities with them; for example, she read notes with them slowly and explained everything. Ryoko described the experience of reading notes with her facilitator as 'like [reading with] my mum'. Overall this approach could be described as a structured approach to facilitation with a style of 'asking'.

A second theme identified that helped student **access learning opportunities** was the *relationship* students developed with their facilitator. Qualities students commented on including being 'nice', 'friendly' and comfortable', which made it easier for students to ask questions. Most students interviewed felt that their facilitator had been friendly and approachable.

Challenges to learning

Whilst all students talked about what they had learned from facilitators, they also talked about the **challenges to that learning**. Key themes in this category were the *pedagogic practices* of the facilitator; the students' *confusion about expectations* during clinical placement, students' own perception of their *English language performance*; and the *power relation* that students perceived between the facilitator and their buddy RN.

In terms of the overall *pedagogic approach to organising the day* one of the challenges students talked about was the limited time they spent with their facilitator. This limited time seemed to particularly affect students who felt a lower sense of agency in their learning and who did not feel they were learning much from their buddy RN. Angie felt she learned 'only basic things' because she had few opportunities to engage with the facilitator on an individual level or with other

students in the debrief. In Green Hospital debrief was not held every day and the facilitator's overall approach was a less structured, more opportunistic style that relied on students asking questions to gain access to other learning opportunities. One student, Jing, appreciated this approach, whereas it was challenging for Angie. Similarly, while Maymei was more confident about asking her nurse, and confident in caring for her patients, she too felt that her learning had been limited, partly due to the time constraints of the facilitator. She thought it would have been helpful for her to have more regular and lengthy contact with the facilitator and to have a debrief every day. In Maymei's opinion, debrief was the most important thing.

The teaching style of the facilitator could also make learning challenging for students. They talked about the pace of talk being too fast. Some students also felt that their facilitator talked too much, which sometimes resulted in them being overwhelmed by the amount of information in long sessions. This style could be summed up as 'telling' rather than 'asking'. A telling style refers to interactions where the facilitator provided students with information, and did not usually engage in a dialogic interaction with them. In contrast, when using an 'asking' approach, the facilitator engaged in a dialogic interaction with students, eliciting information from them and providing opportunities for students to talk. These styles are referred to in more detail later in this chapter and throughout later chapters.

A second theme in this category was the confusion students felt about what was expected of them during clinical, both in terms of what their role was and what the facilitator expected them to do on a daily basis. Hongyan, for example, was not sure if she was 'a temporary helper or a student' and consequently was reluctant to take time out to look things up on the computer, which would have given her access to information about patient conditions. She felt awkward at the computer because she felt she should be doing something rather than sitting at the computer. Not all students were sure what their facilitator wanted them to do.

A third theme that contributed to making learning challenging was the *relationship between the RN and the facilitator*. Students often referred to this relationship in

terms of power. They commented on the fact that RNs and facilitators had different ways of performing clinical skills and different expectations. The buddy RN, as an expert within the local community practice of the ward, may have developed ways of completing clinical tasks that were part of the shared repertoire on the ward but were not in accordance with standard practice. The clinical facilitator, as the expert in the broader community of practice of the nursing profession, and as a representative of the university community, usually followed standard procedures and commented to students when they saw non-standard practices. It was difficult for students to know which expert to follow. If the facilitator was there, students would follow what the facilitator wanted but if students were working with the RN when the facilitator was not present, they would usually follow the RN's instructions. This behaviour sometimes led to students not performing proper hygiene procedures and undertaking tasks outside their scope of practice.

The RN and the facilitator both have the status of experts compared to the students' novice status and both play a role in their learning. Problems seemed to arise when they are all in the same space. Angie worried about offending the nurse if she asked the facilitator questions when her buddy RN was present because she thought the buddy RN would wonder why Angie was not directing questions to her. Soo-jin talked about being embarrassed about learning with the facilitator in front of the RN. She referred to a few times when the facilitator corrected something she was doing according to her buddy RN's instructions. Students described themselves as being caught between the RN and the facilitator and, although facilitators I saw always introduced themselves to the nurses and talked about who they were and what the student were doing, there still seemed to be tensions between some facilitators and nurses, if not openly. Soo-jin for example said the nurses kept asking her what the facilitator was doing and why was she around all the time.

A third theme that constrained students' learning was their perceived level and attitude to their English language performance and competence. Hongyan said she expected to learn more during clinical placement about the way nurses think. However, she found that she had to focus on what they were saying in order to

understand them and this did not allow her to focus on how they were thinking. She felt awkward with nurses because she felt her English was a barrier and that this limited her performance in nursing. Hua was nervous about speaking English when the facilitator was observing her. Soo-jin, Mouy, Binh and Dilip all talked about being nervous when speaking in front of a group of students in the debrief but at the same time they also talked about the growing confidence that came with doing that on a regular basis. Some students, for example Hua, were more nervous about speaking when working individually with the facilitator than they were when speaking with a group.

Those students who were more confident with their language performance did not see English language as a hindrance. Jing said her language was not good enough but it was not a big problem as she always clarified. Soo-jin had been worried about her English performance before her clinical placement occurred. She met regularly with a group of fellow Korean students to talk about their English and what would happen or had happened during placement. Soo-jin said that all of her peers were anxious about their English language. However, she said not much attention was paid to English during her placement and it was not really a problem for her. Neither Jing nor Soo-jin saw their level of English as limiting their learning.

Student agency

This final category helped provide access to learning opportunities, but it also constrained learning opportunities. Access or constraint depended on students' own sense of agency and how that interrelated with the facilitators' pedagogic practices, and the students' perceptions of their level of English. Students' sense of agency influenced their view of what they had learned during the clinical placement. They mostly talked about their sense of agency in relation to working with buddy RNs, rather than facilitators. However, it seemed to me that the students' sense of agency also affected their access to learning opportunities with facilitators. Some students had a high sense of their own agency in learning, whereas other students seemed to be *wanting direction*. Soo-jin felt it was up to her to be involved, to 'have a go' even when she was not 100% sure of what the task was. Other students, like Angie, were more dependent on nurses telling them

what to do and were disappointed when they did not receive that guidance. Angie felt the 'nurses don't teach you, you just stand around'. Jing, on the other hand felt '*grabbing opportunities'* was important. She also set her own goals to be an independent practitioner and drew on all resources to achieve this goal, including other nurses and the facilitator. Similarly, Soo-jin felt it was 'up to the students' to be involved and Maymei felt it was students' responsibility to explain the scope of practice to the RN and to build a relationship with the RN. In reflecting on her clinical placement, Angie seemed to be aware that she might have received more learning opportunities if she had asked more questions and said that she would do so during her next clinical placement.

According to these students' views, it seems that learning in the clinical environment for students who speak English as an additional language is influenced by a complex set of factors including students' sense of agency, their perception of their English language competence and the pedagogic practices of the facilitator. For some students, the interplay between these themes resulted in positive learning and language socialisation opportunities. For others, it resulted in limited learning and language socialisation opportunities. Across the three hospital sites, it seemed that there was the greatest variation in the students' experiences in Green Hospital. In Green Hospital, one student, Jing, had 'a fabulous clinical placement', another, Hongyan, gave it '6 out of 10' and another, Angie, felt it was good but her learning was limited.

From these interviews, it seems that facilitators influence students' access to learning opportunities. It also seems that facilitators' pedagogic practices in terms of how they managed the overall approach to facilitation, as well as their pedagogic style, in terms of 'asking' or 'telling' can extend or constrain learning and language socialisation opportunities.

Facilitators' perspectives

The interviews with clinical facilitators were held during the last two days of clinical placement. The interviews were analysed for themes, which were then grouped into one large category, **facilitating EAL students**. This category had

three themes: *inclusive attitude* towards students; *beliefs about language*; and *strategies for EAL students.* The themes are summarised below (Table 7).

Table 7: Themes from interviews with facilitators

CATEGORY	THEMES	TOPICS
Facilitating EAL students	*Inclusive attitude:*	Linguistic diversity is normal
		Different expectations for EAL students
		Benefits of L2
	Beliefs about language	Language develops over time
		Language is only one aspect of nursing
		Language is separate from clinical
	Strategies for EAL students	Speaking slowly
		Using repetition
		Explaining things
		Telling students they need to communicate

Overall, facilitators thought the placement was as they expected and were satisfied with students' performance. It was clear from the interviews that the attitude of the facilitators was, on the whole, one of *inclusivity*. Facilitators regarded linguistic diversity in the workplace as normal and suggested people need to 'develop an ear' for understanding people from different language backgrounds. The facilitators considered it the responsibility of all speakers to clarify meaning rather than the responsibility resting solely with the EAL speaker. As Mel said 'you need to develop an ear and clarify yourself as an English speaker'. This *inclusive attitude* resulted in facilitators having *differing expectations of EAL and native speaker students*. The facilitators talked about 'giving leeway' to EAL students in terms of communication based on the understanding that English was not their first language. The inclusive attitude also extended to the kind of behaviour they expected from the students. Kim, the facilitator in Green Hospital, noted that while small talk was important and patients enjoyed it, there were many different kinds of nurses and some nurses were quieter than others. Kim did not interpret being quiet as problematic, unlike facilitators in previous research (Brown 2005).

Partly these differing expectations arose out of the facilitators' beliefs that language was a process and took time to develop. It also seemed that language was only one aspect of what facilitators were focusing on when assessing students. Glenda argued that she was concerned that some facilitators would fail students based on communication alone but she thought this was wrong, as language was only part of the nursing process. Mel saw language as a separate thing from nursing and talked about her reluctance to assess language, as she did not feel qualified to do so because she was not a language teacher. The advice she gave to students about improving English was, she said, recommendations only, based on her opinion. She said she would not write comments on their assessment form about English as she was not qualified to do so. Mel had mentioned to me during the placement that she was particularly worried about one student's language but when I asked her about this student, she said she was worried about her communication but not her knowledge 'because she's got it I just have to always ask her what she's trying to say'. Mel looked for what students were doing clinically because 'that's where our concern is'. She suggested that 'maybe we need language specialists to decipher if they are clear or not in that setting, I can only say clinically'.

A final theme was *strategies facilitators used for EAL students*. Glenda thought that perhaps she spoke more slowly and repeated things more for EAL students. Kim said she thought more about the words she used; for example, if she used colloquial language, she explained it. Kim also said she *told students to communicate* with their patients

Themes from my field notes

Field notes from the three hospitals were analysed for key themes, which were then grouped into larger categories. Table 8 shows the six categories and their associated themes.

Table 8: Key themes from field notes

CATEGORY	THEME
Space	*Workplace spaces*
	Education spaces
	Finding spaces
Learning opportunities	*Equal*
	Unequal
Pedagogic practices	*Overall approach*
	Teaching style
EAL learners	*Facilitator strategies*
	Inclusivity
	Challenges for students
	Student strategies
Becoming a nurse	*Thinking like a nurse*
	Practising like a nurse
	Dealing with challenging situations
Relationship building	*Aligning with students*
	Showing interest in students' lives

One of the key categories was **space** both in terms of trying to find space where facilitators and students could meet and how moving between spaces seemed to offer learning opportunities. Facilitators looked for rooms where they could meet with students and there were sometimes tensions about which rooms could be used by whom. In Green Hospital, most of the interactions with the facilitator seemed to be in the patient room unless students raised matters that needed to be followed up elsewhere, for example at the nurses' desk. In Blue Hospital, interactions with students and facilitators were often away from the patient room and nurses' desk and were in tea rooms and meeting rooms. In Red Hospital, interactions between facilitators and students seemed to be distributed equally across all spaces.

A second category was **learning opportunities**. In Red and Blue Hospitals, the learning opportunities seemed to be more equally distributed across students than

they did in Green Hospital where some students seemed to gain access to more learning opportunities than others.

A third category was the **pedagogic practices** of the facilitators. This category had five themes. The first theme referred to the *overall pedagogic approach* that facilitators adopted during the clinical placement. This approach ranged from one that was more structured and where students had allocated time with the facilitator, individually or in groups, to one that was more opportunistic. The latter seemed to be based on a 'checking-in' approach where the facilitator asked students if they had any questions. If they did, then they seemed to gain access to more learning opportunities.

A second theme within this category was the *teaching style* of the facilitators. This seemed to vary between an approach that could be called 'telling' where the facilitator gave information and did most of the talk to one that relied on 'asking' where the students seemed to have a lot of talk time. Along with this 'telling' approach it seemed to be difficult for students to get the floor and this often resulted in students not having much talk time. In contrast where an 'asking' approach was adopted students seemed to get more talk time.

A fourth category was **EAL learners**. One of the themes in this category was the explicit strategies facilitators used that seemed particular to EAL students. Although language was rarely explicitly commented on with students, facilitators did use strategies to explicitly focus on language; for example, when they encountered unfamiliar words, the facilitators would spell the words, write them down and tell students to ask if they did not understand. Glenda, Red Hospital, seemed to use a slower pace of talk than the other facilitators and also left extended silences when waiting for responses from students.

A second theme in the **EAL learners'** category was *inclusivity*. Facilitators focused on students' strengths, noticing that they were asking good questions. In Green Hospital, in particular, speaking another language was seen to be an advantage. When students and patients shared a first language, and the patients did not speak

any English, RNs called upon students to speak to the patients. It seemed that linguistic diversity was part of the normal workplace and facilitators worked around any difficulties in communication. A third theme was *student strategies*; students had ways of managing communication in the workplace. They used touch, smiling and showing patients equipment instead of talking, or to accompany minimal talk. However, there were also *challenges* for students. Firstly, it was difficult for some students to gain the floor to talk either with the facilitator alone, or in a group debrief. Secondly, it seemed students were sometimes overloaded with information.

A fifth category was **becoming a nurse** and this category revolves around the key professional themes focused on in learning to be a nurse. These were *thinking like a nurse*, *practising like a nurse* and *dealing with challenging situations*. Some facilitators focused on helping students to think like a nurse by planning and prioritising care and by thinking critically about their patients and the healthcare practices they viewed. In terms of practising like a nurse, the main focus was on the daily routine (clinical skills and nursing tasks) and hygiene practices. Another theme in this category was dealing with *challenging situations*, including death and in the case of one student, sexual harassment and bullying.

The final category was **relationship building**. Facilitators spent time establishing and maintaining a relationship with students by showing interest in their lives and aligning themselves in different ways. One facilitator said she could 'bend the rules' as she understood how challenging their lives were. Another often identified with the challenges of learning to be a nurse recounting her own challenges in learning when she was a student and new nurse. Facilitators also spent time building relationships with RNs in order to provide productive learning opportunities for the students.

The above analysis of interviews and my field notes has identified what students can learn during clinical placement. It has also identified factors that enable and/or constrain opportunities for EAL students to learn during clinical placement. However, this thematic analysis only gave an overview of what was going on in the

clinical placement and did not capture in detail the differences and similarities across the sites. As noted in the analysis of students' perceptions, I also noticed the importance of the facilitator and the pedagogic approach in extending or constraining learning but it seemed that an interplay between the pedagogic approach, the style and spaces could minimise the importance of student agency. This interaction is illustrated in Figure 2

As noted in Chapter 4, in order to interrogate these themes further, field notes and audio recordings were reanalysed, using a framework that mapped the interactions according to where the interaction took place; who was involved; what kind of interaction it was; how it unfolded, and whether language played a part or was commented on in any way. From this analysis, space and activities seemed to be closely interlinked and the data were reorganised according to the major spaces in the clinical setting. As spaces are the larger and more tangible entity, and as facilitators often talked about space as we walked around the hospitals, spaces have been used as my framework for analysis of activities. This is mapped in the next section.

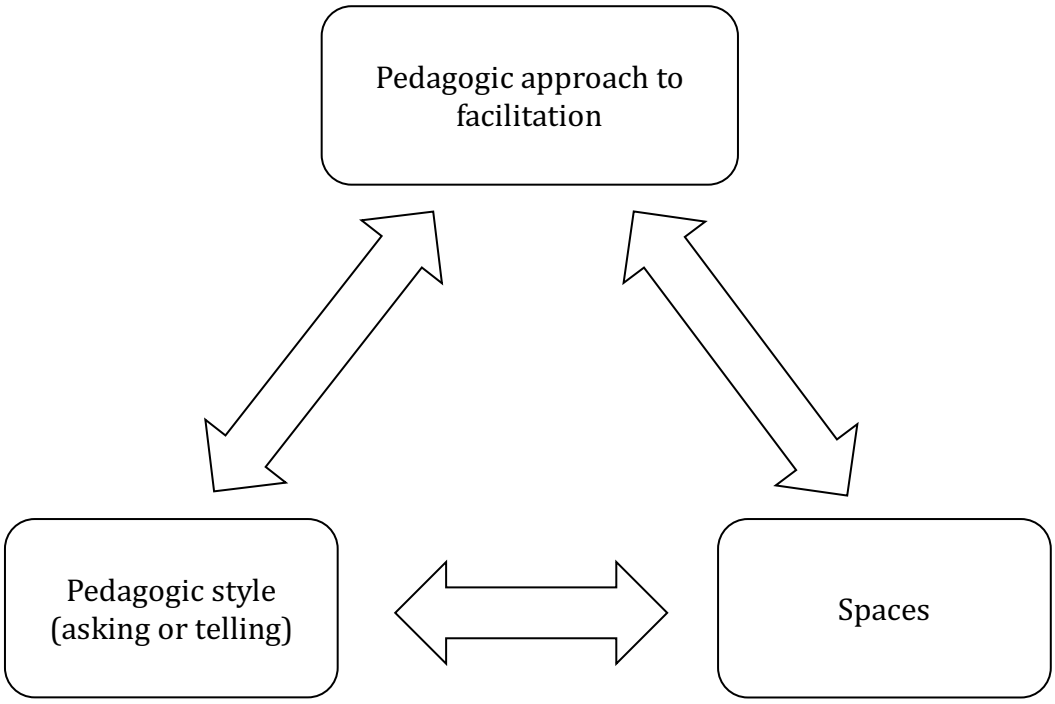


Figure 2: Influences on learning during clinical placement

Mapping spaces in the clinical setting

Each space in the hospital was associated with particular activities. Table 9 below shows the key spaces where activities occurred; the corridor, the patient room, the nurses, desk, and a number of other spaces, which I have grouped together as 'ad hoc spaces'. The table also shows the activities that occurred in each space. Few activities regularly occurred across different spaces. One activity that occurred across two spaces was *reading patient notes*. However, the activity was the same in both spaces, the nurses' desk and ad hoc spaces, and the facilitators used these spaces to sit together with the student and both look at the notes at the same time. A second activity *setting up the shift*, occurred in two different spaces. In Red Hospital, it occurred in the corridor and in Blue Hospital, it was in a meeting room or tea room space. Although categorised as the same activity, as the purpose of both seemed to be to help students set up their shift for the day, the focus of the activity in each hospital was quite different.

Table 9: Spaces and activities in the clinical setting

Corridor	Setting up the shift
	Checking in
	Follow up talk about bedside interactions
Patient room	Observing bedside interactions
	Working alongside
	Demonstrating how
	Talking about patients
Nurses' desk	Reading and talking about patient notes
	Researching and talking about patient conditions and medication on online systems
Ad hoc spaces (meeting room; tea rooms; patient lounges; hospital canteens; outdoor spaces)	Setting up the shift: handover
	Debrief
	Formal assessment

There were four main spaces in the hospitals where activities occurred. These were **the corridor**; **the patient room**; **the nurses' desk** and **ad hoc spaces.** The **corridor**, the **patient room** and the **nurses' desk** were all specific to the ward where students were working. For example, three students worked on a neurology ward and the corridor, the patient room and the nurses' desk were located within that ward. The sketch below shows a typical layout of the ward, incorporating the different spaces. It does not depict specifically any of the three hospitals but is a collage of all three. This was deliberately done to protect the confidentiality of the hospitals and the participants.

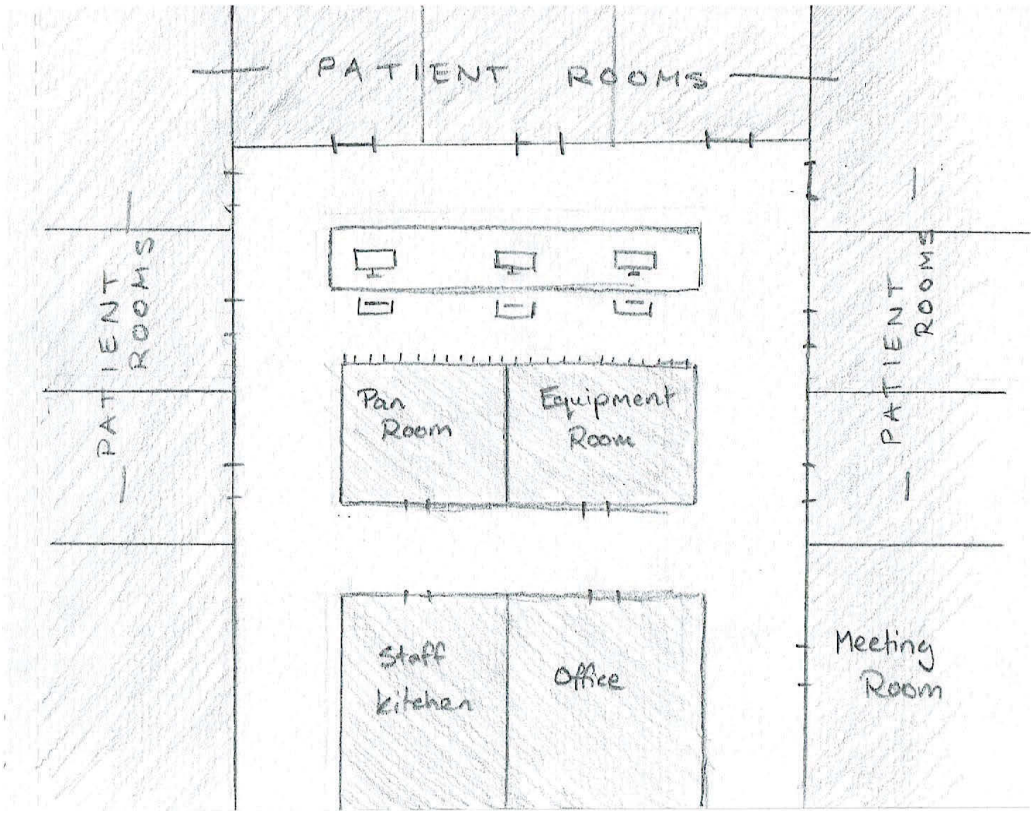


Figure 3: A typical ward in the hospitals

The term **ad hoc spaces** is used to depict the variety of spaces used for particular activities and the ad hoc nature in which facilitators had to find these spaces. **Ad hoc spaces** could be part of the ward, or they could be spaces that were between wards, and finally they could be located away from the wards. Ad hoc spaces included the hospital canteen; an outdoor café; tea rooms on the ward; patient lounges; and the pan rooms, that is the room where bad pans were kept and

sanitised. An example of a space between the wards was a large patient lounge room in Red Hospital that was centrally located in the corridor that connected three wards, as illustrated in Figure 4 below. The lounge could be used by visitors and patients from all three wards. Ad hoc spaces away from the wards included the hospital canteen in Green Hospital and, in Blue Hospital, an education room that was located in a separate building. Whilst students spent most of their time in their own ward, they sometimes joined the facilitator and other students in an ad hoc space on a different ward or in a space between wards for the end of day debrief.

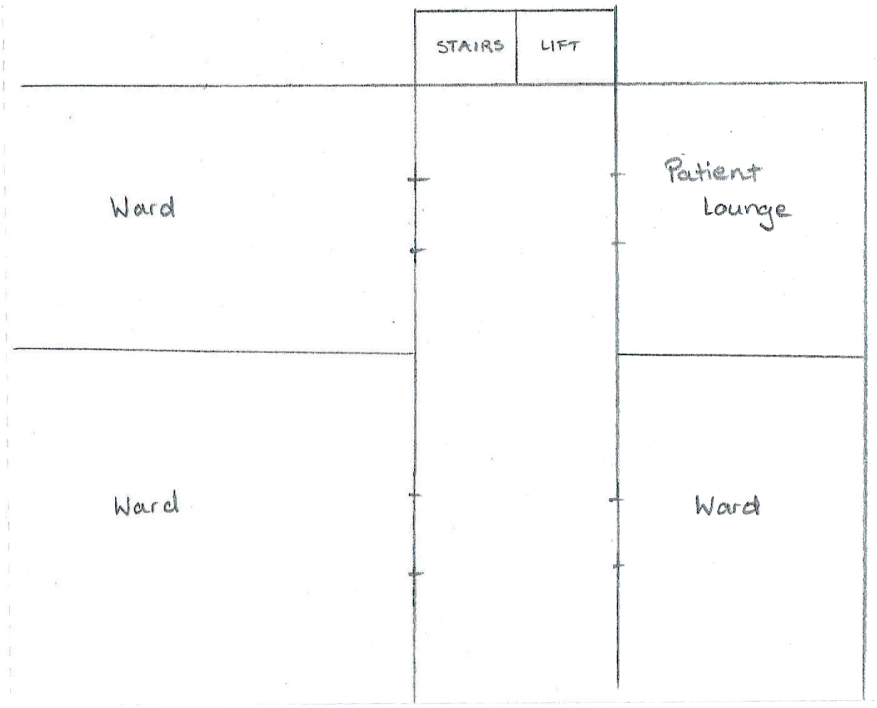


Figure 4: Spaces between wards

A previous study that used space as a framework to analyse data (Gregory 2016, p. 108) categorised spaces as public or private. In that study, private spaces were 'concealed from view' and 'considered private by the nurses'. They were spaces where nurses could talk away from families and patients. However, although the ad hoc spaces in my study were private in the sense that they were away from the hustle and bustle of the wards, many of them were spaces used by the public and by other healthcare staff.

There were very few **quiet and private** spaces (private in the sense that students and facilitators would have aural and visual privacy) available to students and facilitators in the hospital. Figure 5 below shows the spaces where facilitators and students met on a scale from public to private, and noisy to quiet. Some spaces, for example, the corridor and the nurses' desk were visible to others but the background noise, and the way in which facilitators and students positioned themselves in the space created a semi-private space where they could usually not be overheard. The use of public spaces as learning spaces could be challenging, particularly when the background noise made it difficult for students to hear. The most notable example of this was the use of the canteen in Green Hospital.

Public → **Private**

Seen and overheard patients; staff; visitors	**Seen but usually not overheard** patients; staff; visitors	**Sometimes seen/overheard** potential to be interrupted by staff	**Not seen/overheard**
1.Patient room	1.Corridor 2.Nurses' Desk 3.Canteen	1.Pan room 2.Tea room 3.Patient lounge on the ward	1.Patient lounge between the ward 2.Meeting room

Background noise → **No background noise**

Variable background noise patient buzzers; voices; equipment	**Little background noise** voices, background noise from corridor	**No noise**
1.Patient room 2.Corridor 3.Nurses' Desk 4.Canteen	1.Pan room	1.Patient lounge 2.Meeting room

Figure 5: Public and private meeting spaces

The next section describes each of these spaces and the activities that occurred in them.

Space one: the corridor

The corridor played a central role as a space where facilitators and students could be seen but usually not heard by other healthcare professionals. It was a space where facilitators could monitor students' activities, interactions and progress. It was also a transit and a 'gateway' to other spaces. The corridor had three key activities. They were: *setting up the shift*; *checking in*; and *follow up talk about bedside interactions.*

Setting up the shift refers to an activity where the facilitator ensured that students had a buddy RN and patients to work with; and where they established with students, and sometimes buddy RNs, what facilitators expected students to focus on during clinical placement. *Checking in* activities occurred as facilitators walked around the wards where they were supervising students. There were two types of *checking in* activities. In the first type, facilitators *monitored expectations* by asking students questions to determine whether they were doing what facilitators had asked them to focus on. A second type was where the facilitator walked around the wards, visiting students and *responded to questions*. The third activity, *follow up talk about bedside interactions,* occurred when the facilitator had watched a student completing an activity in the patient room, or had joined students in watching other healthcare professionals complete a clinical activity. The facilitator then directed students to the corridor to discuss the practices observed.

The corridors connected the patient rooms with each other and with all the other rooms on the ward, for example, the nurses' desk, the tearoom, and the meeting rooms. However, they were also a place for keeping equipment. Blood pressure machines were often kept in the corridors and, in one hospital, equipment to mobilise patients was stored to one side of the corridor. In one of the hospitals the board that contained all the information about patients was situated in the corridor opposite the nurses' desk. This information included patient details, their medical condition, who their doctor was, whether they needed any other healthcare services for example, physiotherapy. There were also noticeboards in the corridors, which had posters relating to hygiene and medical conditions related to the patient on the wad. The corridors were often noisy with beepers

from IV machines frequently signalling they needed attention, buzzers from patients calling for nurses, and rattling trolleys with equipment and meals being pushed along the corridor. Staff also at times called to each other across the corridor to request help. Porters pushed patients to and from procedures. And family members walked around in-between visiting their family.

Space two: the patient room

The patient rooms were located on the wards. Students and facilitators worked in patient rooms, with or without RNs, caring for patients and learning how to use equipment. As illustrated in Table 9 above, there were four types of activities in patient rooms: *observing bedside interactions*; *working alongside*; *demonstrating how*; and *talking about patients.*

Observing bedside interactions occurred across all hospital sites. Usually the student was carrying out a clinical activity with the patient, and the facilitator mainly observed the student. Clinical skills that were regularly observed included taking vital signs, that is, blood pressure, temperature, pulse and respiratory rate, and taking a blood sugar level. *Working alongside* refers to an activity where students and facilitator worked together to complete a clinical activity with a patient. Activities completed in this way included moving patients in the bed and completing an electro cardiogram. Embedded within the above activities was small talk, which was usually performed by facilitators rather than students. The activity *demonstrating how* tended to be in the patient room but away from the patient bedside and involved the facilitator showing students how to use and prepare equipment, for example how to prime an IV line, that is, get it ready to administer to a patient. Similarly, *talking about patients* when conducted in the patient room usually occurred away from the bedside without the involvement of the patient.

The wards where I observed students had approximately 20 patient rooms per ward. Each ward focused on a specialty, for example, renal care, palliative care, and neurological care. The wards were busy, with people coming and going for procedures (e.g. x rays, radiology, CAT scans, endoscopies), new patients arriving and others being discharged. Some patients were there for the whole two weeks of

the placement, others only for a day or two. The patient rooms were the focal point for students, as that was where they worked with their buddy RN to carry out patient care. Work patterns across the rooms varied among students, depending on their buddy's patient allocation and the system of work operating on the ward. On each shift, RNs was allocated patient loads and students were allocated to a buddy RN. On some wards, all of an RN's patients were located in one room, while in other wards, RNs worked across different patient rooms. Hence, some students spent most of their day in one room with four patients, whereas other students worked across a number of patient rooms. In the rooms, RNs went about their daily routine care, which included observations, showers, washes, meals, medications, and dealing with emergencies as they arose. The rooms were also frequently visited by other hospital staff such as doctors, social workers and cleaners.

Most patient rooms opened onto the corridor without a door and had approximately four beds and were for both male and female patients. The beds were located around the walls of the room and each bed had curtains that could be pulled for visual privacy. At the end of the patients' beds were the sets of charts for each patient, including charts for recording vital signs (blood pressure, temperature, pulse and oxygen level). Along the wall, behind the beds, was equipment to administer oxygen and suction. Some of the rooms contained single beds only and these were often for patients with hospital acquired infections that required staff to wear contact precautions, that is protective clothing before entering the room. Sometimes the single rooms were used for patients who were nearing the end of life. Each room also had one or two bathrooms. In Green Hospital, each room also had a small desk and computer for nurses' use. Equipment that was used regularly for observations, such as the machine to monitor blood pressure, was usually located in the corridor.

The noise levels in the rooms varied. At times, they could be very quiet as patients pulled their curtains around their beds and rested. At other times, there was a lot of activity. The morning tended to be busier, as that is when the doctors usually did their rounds and sometimes they had groups of students following them.

Sometimes doctors and other healthcare professionals gathered around the end of the bed to discuss patient conditions. Often family members were sitting beside the bed or entering and leaving the room. There seemed to be ebbs and flows of busy periods throughout the day, punctuated by mealtimes and the associated tasks of serving, eating, feeding, and clearing away.

Space three: the nurses' desk

The nurses' desk was a main space for learning activities in two of the hospitals. The reasons it may not have been a space for activity in the third hospital is that the desks were smaller in size, making it difficult to find enough room for two people to sit. The nurses' desk was located in a central place on the ward. The two main activities that occurred at the desk were: *reading patient notes* and *researching information about patients*. These activities were often carried out at the desk for pragmatic reasons. Patient documents were kept at the desk and there were also computers where hospital systems could be accessed to get information about patient results and access research about patient conditions.

The desks in two of the hospitals were spacious and had a lot of desk space with computers and patient folders on shelves or racks behind the desk. The nurses' desk was often a hub of activity with nurses, doctors and other hospital staff gathering there to find patient information, complete their documents and consult with each other. The desk was also a place where the staff chatted socially with each other.

Space four: ad hoc spaces

The fourth space was not one space but a number of spaces, classified as ad hoc spaces. The spaces emerged from an attempt to find places where facilitators and students could retreat from the busy daily routines of the wards. As noted above, whilst some of these spaces were quiet, others were noisy. The main activities that occurred in these spaces were the *debrief* and the *formal assessments*, both formative and summative. The *debrief* was where students met at the end of the day to discuss their day with the facilitator. In Red and Blue Hospitals, it occurred in a patient lounge or a meeting room where there was usually no background

noise and the only participants were facilitators and students. In Green Hospital, there were only a few *debriefs* and they occurred in the indoor canteen and outdoor café.

Ad hoc spaces varied in style, location, size and noise levels and in the likelihood of being disturbed. The tearooms on the wards were quite small and usually had a table at the centre, with approximately six chairs around it and sometimes armchairs along the edge of the room. These rooms were used by staff during their breaks but during either side of break times they were usually quiet. The patient lounges on the ward were also small. They usually had armchairs or a sofa and a small coffee table. They did not seem to be used by patients and visitors very much during the time I was there. However, on one or two occasions, the facilitator and student using the lounge were asked to leave, as the room was needed for another purpose. The patient lounge that served multiple wards was much larger and had armchairs that could be moved around. Only Red Hospital had this kind of room. As students were on an evening shift in Red Hospital, the *debrief* was usually around 9pm at night when most visitors had left. We were rarely disturbed in the patient lounge.

Only the facilitator in Blue Hospital used the meeting rooms on the wards as a quiet space. These rooms tended to have large tables in the middle and a whiteboard. The facilitator needed to ask permission to use these rooms. Sometimes it was granted but at others not, depending on the nursing unit manager who was in charge of the ward. These rooms felt more like a classroom space as students sat around the table. In Blue Hospital, an ad hoc space, usually a tearoom or meeting room, was also used for *setting up the shift*. In this activity, the facilitator met with students individually at the beginning of the day and students performed a practice handover. This handover included telling the facilitator who their patient was, why they were in hospital and when they were going home. This *setting up the shift* activity in Blue Hospital was closely related to the end of day debrief and is discussed in Chapter 10.

Occasionally facilitators used other spaces such as the pan room, or the equipment room. This was usually when they wanted to talk to students about something that had gone wrong. Mostly these discussions focused on ensuring students were working within their scope of practice, and making sure they were always with a buddy RN.

Movement across spaces

There were also particular patterns in moving from one space to another. This movement was important in that it gave access to the learning activities that occurred in other spaces. One important trajectory seemed to be moving from the corridor or the patient room to other spaces. Moving **from the corridor or the patient room to the nurses' desk** resulted in opportunities for students to spend time with the facilitator reading patient notes and looking at information on the hospital intranet about patient conditions and results. Moving **from the patient room to the corridor** seemed to offer more extensive opportunities for talking about the interactions between patients and students in the patient room that the facilitator had observed. This movement relates to one of the key themes, 'pedagogic approach', from data on student and researcher perspectives (discussed earlier). Student movement from one space to the other seemed to be dependent on the overall pedagogic approach the facilitator adopted, that is whether it was a more deliberate, structured approach or an opportunistic, ad hoc approach. Students who had limited access to the multiple spaces, such as Angie, felt their learning had been limited.

The challenge of finding space

It was not always easy to find spaces where facilitators and students could talk and facilitators were well aware of this. Glenda, the Red Hospital facilitator, talked to me about how difficult it was to find space to talk with students and said usually there is only the corridor. Here in particular she was referring to times when she wanted to talk to students about things she had observed in the patient room. Similarly, Mel at Blue Hospital, seemed, in the first few days, to spend a lot of time looking for spaces where she could meet with students. She asked educators and nurse unit managers on the ward for permission to use the meeting rooms. After

gaining permission from one unit manager to meet for the daily debrief, she was later told she could not use the room, as the manager had not realised she was gathering there on a daily basis with all students, including students who were located on other wards. The room needed to be available for staff on the ward to use. There was a sense that there was no designated place for facilitators, nowhere to deposit their bags, nowhere to arrange to meet with students, and nowhere that they could be sure that they would not be disturbed. In this way, facilitators were excluded from the local community of practice of the ward. Facilitators found ways of working around this by creating learning spaces in the corridor, at the nurses' desk, in the tearoom and in the patient lounge.

Conclusion

This chapter provides an overview of the key themes that arose from the student and facilitator interviews and my field notes. It shows how space and the pedagogical approach and strategies adopted by facilitators interact to enable and/or constrain opportunities for students to learn in the clinical setting. These themes form the basis of the rest of the chapters in this thesis. Previous research that is relevant to these findings is discussed in the following chapters, each of which discusses one of the spaces mentioned above, and activities that occurred in that space. Each chapter also discusses the pedagogic approach and style of the facilitator within each space, and student perceptions of what occurred. Conclusions are drawn in each chapter about how each space, combined with the pedagogic approach and style of the facilitator, and students' own sense of agency and perception of their English language, extended or constrained opportunities for student learning. Each chapter also considers how the particular spaces and pedagogic styles provided access to opportunities for language socialisation for EAL students and affected their language performance. Finally, each chapter also considers the opportunities provided in each space for facilitators to assess students' performance in terms of nursing skills and knowledge and English language.

Chapter 6 - Corridor: gaining entry

Previous studies have found that hospital corridors are places where inter-professional communication occurs (Gregory, Hopwood & Boud 2014; Iedema et al. 2006; Long, Iedema & Lee 2007) and where nurses can talk to each other about patients without being overheard (Gregory 2016). They are sites of intense productivity and central to the 'managing of complex and highly patient-centred care processes' (Iedema et al. 2006, p. 239). They are also places where professionals reflect on their practice and attitudes (Long, Iedema, & Lee 2007) and where they communicate with each other socially (Gregory 2016; Long, Iedema & Lee 2007).

Amidst this hustle and bustle of movement, learning also occurs. Eggins (2016) notes how senior doctors teach junior doctors as they are walking down hospital corridors moving between patient consultations. Other studies have focused on ad hoc learning by junior doctors in General Practice settings, where junior doctors seek advice from their supervisors to confirm patient diagnoses (Morrison et al. 2014; Pearce 2003). However, there are to my knowledge no previous studies that consider how the corridor is used as a place where students gain entry to the workplace and to learning spaces within that workplace. In my study, the corridor was used in two ways. Firstly, it was used to help students gain entry to the workplace and as an access point to other spaces on the ward where students could spend time focusing on learning activities with the facilitator. This use of the corridor is discussed in this chapter. Secondly, it was used as a deliberate site of learning after observations in the patient room. That use of the corridor is discussed in Chapter 8.

The hospitals where clinical placements take place are primarily workplaces rather than educational institutions and facilitators need to work within the daily routines of RNs, who work alongside students as buddy nurses. During the shifts, facilitators walked around the corridors on 'daily rounds' of the wards where students were placed, observing what students were doing and seeking opportunities for engaging with students. The corridor then was central in the

creation of opportunities for interactions with students and their buddy RNs. It was a space where facilitators could monitor student activities and decide whether there was anything to watch or comment upon; where they could monitor students' progress with a quick question or by asking students for something specific, such as a plan of care. Long, Iedema and Lee (2007, p. 189) found that the corridor 'enabled clinicians to adopt a bird's –eye view on their tasks and on patients' care trajectories'. In my study, facilitators used the corridor to adopt a bird's-eye view on students' activities.

This chapter discusses how facilitators used the corridor to help students gain entry to the workplace by helping them *set up their shift* by ensuring they had organised buddy RNs and patients; and by *setting expectations* about what to focus on during the placement. It also discusses how the corridor was a space where facilitators could *check in* with students to *monitor* their performance in terms of meeting expectations, and to answer any questions. It focuses on how the pedagogic approach facilitators used in the corridor helped or hindered students from engaging in the work environment, and from gaining entry to other spaces on the ward which provided opportunities for being socialised into the nursing profession.

Activities in the corridor

As summarised in Table 10 below, the corridor had three key activities: *setting up the shift*; *checking in*; and *follow up talk about bedside interactions*. These activities varied across the three hospitals. This chapter focuses on two of these activities; *setting up the shift* and *checking in*. *Follow up talk about bedside interactions* is discussed in Chapter 8. Table 10 also shows the goals and focal themes of each activity across the three hospital sites.

Table 10: Activities and focal themes in the corridor

ACTIVITY	GOAL	FOCAL THEMES in the three hospitals	
Setting up the shift	*Organising buddy RNs & patients*	Red Hospital	Choosing/following the buddy RN Choosing patients
		Blue Hospital	NONE
		Green Hospital	
	Setting up expectations	Red Hospital	Caring for one patient, reading the notes; making a time management plan
		Blue Hospital	Knowing your patient; using the handover sheet Making a plan
		Green Hospital	(week 1) Working with your buddy (week 2) Caring for a patient
Checking in	Type 1: deliberate *Monitoring expectations*	Red Hospital	Making time management plans and reading notes
		Blue Hospital	Knowing information about patients
	Type 2: Ad hoc *Responding to student questions*	Green Hospital (to a lesser extent Blue & Red)	Patient care: medical conditions & procedures
			Scope of practice
			Troubles telling (re. concerns of patients or students)
Follow up talk about bedside interactions	Discussed in Chapter 8		

Setting up the shift (activity one): organising buddy RNs and patients

As noted in Chapter 1, a key challenge for nursing students is to integrate into the clinical setting. Students need to fit in with a busy workplace, adapt to the rhythm of the ward, find out where everything is located, and appear helpful and competent. Facilitators also need to fit in with this busy work environment and find opportunities within it to help students learn. The facilitator in Red Hospital, Glenda, was the only facilitator who explicitly helped students with this part of the day. *Setting up the shift: organising buddy RNs and patients* functioned as a way of helping students to join a busy, apparently efficient working community where everybody seemed to know what they were doing –except the students. In Blue and Green Hospital, students usually had to navigate the beginning of the shift by themselves. The facilitators in Blue and Green Hospitals did not attend handovers and tended to complete daily rounds after students had already been allocated a buddy RN.

As mentioned previously, during a clinical placement, the supervising buddy RN exerts a strong influence on the student experience (Chiang & Crickmore 2009; Dunn & Hansford 1997; Rogan et al. 2006; San Miguel & Rogan 2009). However, this relationship also has challenges. There is little structure around allocation of buddies, as it is an informal arrangement, whereby students and RNs are buddied on the day, the RNs may know nothing or little about the student or the university where they are from, and they may not be familiar with the limitations of the students' scope of practice. No time or pay is allocated to this role. Due to the nature of shift work, students may be allocated several buddies throughout their placement (some may even change on a daily basis).

The challenge of the beginning of the day

Glenda adopted an intentional and deliberate approach to *setting up the shift*. On arriving on the ward, the first things students did in all hospitals was attend the clinical handover. This process is where the team leader of the shift that is ending hands over information about all the patients on the ward to the new shift of nurses. The handover occurred in a closed room. At the end of this handover, the team leader of the new shift allocated the students a buddy RN that they were to

work with during that shift. When handover finished, nurses and students moved out into the corridor and the bedside handovers were carried out. This is when the RN who had been caring for a number of patients handed over information about them to the RN who would be responsible for them on upcoming shift. This handover was carried out by patients' bedsides or sometimes in the doorway to patients' rooms. This time of day was a busy time on the ward. RNs on the outgoing shift were often in a hurry to leave; RNs on the oncoming shift needed to make sure they had all the information required about patients. There was also often a lot of social chatter as the nurses ended and started their shifts. Gregory (2016, p. 192) describes nurses in this part of the day as 'weav[ing] in an out of bedrooms and corridors, visiting their patients, listening and taking note of any additional information that has not been disclosed during the formal transfer of care at handover'.

Glenda's *setting up the shift* activity happened in the corridor amidst this movement and noise. For novice students, as were the students in my study, the beginning of the day could be overwhelming due to the large amount of new information they heard in handover, and the stress of trying to fit in to the workplace and work out what they were supposed to be doing. Although students knew they needed to go to the handover session on arrival at the ward, the allocation of buddies was not always clear. Sometimes the team leader allocated a buddy but sometimes the students were left to organise a buddy for themselves. It always seemed there was an air of uncertainty as to where they should be and with whom they should be working. Nobody on the ward seemed to greet them and take charge and students needed to be able to work out what to do or ask if they were not sure.

Glenda was aware that it could be difficult for students, particularly EAL students to fit into the ward. She told me that that she herself was feeling overwhelmed, as the hospital seemed very busy and the wards seemed big. Glenda said that it would be overwhelming for students 'who just get thrown in and have to find their feet'. She thought the challenge was exacerbated by nurses who did not welcome the students in the handover room. Rather, 'it was like the students were

invisible'. I noticed in the handovers I observed that, as the nurses waited for the handover to begin, they often chatted socially and laughed together. The students were not included in this chat and often sat or stood at the edge of the handover room. I noticed that often the RNs also did not include students as they left the handover room. They left the students behind and it was up to the students to follow.

The beginning of the shift was also how students could first find out information about patients. Students were given a copy of the handover sheet (a brief written summary of each patient on the ward – approximately 20-30) and while listening to the team leader give a verbal handover, students looked at the sheet and some of them wrote notes on it. At this stage, students did not usually know which patients they would be allocated so they needed to note information about all patients. However, the amount of information provided, the density of medical terms and the use of phrases with specific meanings in a nursing context, meant it could be difficult for students to understand much of this information. Apart from medical terminology, some of the phrases I noted that could be challenging due to the use of colloquial language ('sneaking'; 'they'll see how she goes') or specialised terms ('a light diet'; 'complex social background') were, for example:

> There's still some talk about her sneaking in a few drinks
>
> The patient has been given approximately a month to live- they'll see how she goes with a light diet today
>
> She's got a very complex social background as well

Glenda considered it essential, as a clinical facilitator, to go to the handover and to help students manage this part of the day by making sure the students were buddied up; finding out which patients the students were allocated; and asking the RNs to make a plan with them (discussed in *setting expectations* below). This deliberate approach can be seen as a way of mediating students' sponsorship (Lave & Wenger 1991) into a working community to ensure they had a sponsor to work with (the buddy RN) and opportunities to participate.

Focusing on EAL students

One of the key factors in Glenda's approach to *setting up the shift* was determining which students to spend time with. As handovers began at approximately the same time across different wards, Glenda could only be at one handover each day. As can be seen in Table 11 below, Glenda spent more time with the EAL students on this activity than she did with other students. On two wards, Glenda was supervising three students in each ward. On the ward where all three students spoke EAL (Soo-jin, Mingxia, and Ryoko), Glenda helped organise buddies and patients on five days. On the ward where there was one EAL student (Hua), one who was fluent in English but whose first language was an Indian language (Ravindra), and a student who spoke English as a first language (Hannah), Glenda helped *set up the shift* twice. She did not *set up the shift* with Emma, a native speaker of English who was working on a nearby ward by herself.

Table 11: Setting up the shift: record of activities

Red Hospital	**Organising buddy and Patients**
Day 1	Soo-jin, Mingxia and Ryoko
Day 2	Hannah, Hua and Ravindra
Day 3	Soo-jin, Mingxia and Ryoko
Day 4	Soo-jin, Mingxia and Ryoko
Day 6	Soo-jin, Mingxia and Ryoko Hannah, Ravindra and Hua
Day 8	Hua, Ravindra and Hannah

A second factor in *setting up the shift* was using the corridor to gather with students, and find out who their buddies and patients were. On the first few days, Glenda also accompanied some RNs and students as the RNs walked around the ward, orienting them to where things were. On the first day of placement day, for example, Glenda attended the handover with Soo-jin, Mingxia and Ryoko. At the end of handover, the team leader told the students which RN they were to work with. As the students came out of handover, Glenda asked each of them who their buddies were and wrote down their names on her notepad that she had with her at all times. She explained about the handover process at the bedside and told

students to 'keep an eye on [their] buddies' and to make sure they did 'not lose them'. When bedside handovers began, the students accompanied their RN. Glenda followed Soo-jin and her buddy RN and listened to the bedside handover. Glenda then accompanied Soo jin and her RN on a tour of the ward, noticing things that were important for students and setting things up for them. For example, Glenda asked where students could find a manual blood pressure cuff as she wanted them to take blood pressure using a manual rather than automatic cuff. She also asked about the system of washing bedpans and mouthcare bowls in the pan room.

If buddies were not allocated, Glenda focused on helping students choose patients. On the third day, for example, Glenda again attended the handover with Ryoko, Mingxia and Soo-jin. The team leader had not allocated students to a nurse, saying she did not mind where they were as long as there was one student in each section of the ward. Glenda spent time talking to students in the corridor, to help them decide whether to work with the same patients as the previous day or whether to move and work with new patients. The focus was on the patients more than the buddy. As Glenda helped Ryoko select patients to focus on, it was also an opportunity for Ryoko to contribute what she knew and to ask questions about the patients. Glenda suggested that Ryoko had 'so many interesting patients. The ones I'd ask to look at would be this gentleman here, that person there, this person here'.

Glenda adopted this deliberate approach to *setting up the shift* throughout the placement. This approach was very different from Green and Blue Hospitals where the facilitator visited students on the ward after they had already been buddied up and had been allocated patients. Whereas Glenda believed the beginning of the shift was complicated and challenging, Mel and Kim seemed to have assumed that the buddy and patient allocation process was unproblematic for students. However, it seems for some of the students in Green Hospital that the process of allocating buddies and patients was not clear. On the third day, Priya, one of the students, asked Kim, the facilitator, whether they were supposed to be going to the same patient room every day, as that is what they had been

doing. Kim replied they needed to talk to the team leader to be allocated. Apart from the lack of clarity with the process, the lack of *setting up the shift* resulted in some students feeling that they had not learned much, as they remained with the same patients, and their buddy had not really taught them anything. Angie, for example talked about being 'stuck in the same patient room' and felt in the first week she did not learn much from her buddies, and as the patients were the same felt she was not learning much. Angie felt she had 'nothing to do'.

Most EAL students, but not all, needed guidance with setting up the shift. Some students in Green Hospital were capable of managing the process of finding the best buddy and 'interesting' patients. Jing, who was in the same ward as Angie in Green Hospital, said that she looked for a nurse who could teach her and followed that nurse. She also noticed patients' medical conditions and followed up their cases by asking the facilitator about them, even if they were not her patients. Jing was unusual amongst the EAL students I observed in that she 'took charge of her learning' and felt, as she said, it was up to her to 'grab opportunities to learn'. Jing can be seen as an agentic learner (Billett 2011).

Glenda's deliberate approach to guiding students in selecting patients and making sure they had a buddy relied on her using the corridor as a space to notice where students were standing, what they were doing, whether they were engaged with an RN and in patient care. She approached students to ask who they were working with and spent time talking to them in the corridor, looking at the handover sheet to help select patients to work with. In doing so, Glenda used the corridor for her own purposes, to focus on creating learning opportunities for students.

Setting up the shift (activity one): setting expectations

A second goal of *setting up the shift* was to clarify for students and buddy RNs what facilitators expected students to do during the placement, or during each shift. The activity occurred in all three hospitals, although the expectations of each facilitator differed. The corridor played an important role as a place where facilitators could meet with RNs and students and establish these expectations. The meetings were unplanned and occurred as facilitators completed their daily

rounds of the wards. Mel's (Blue Hospital) expectation was that students knew who their patients were, why they were in hospital, what the plan was for them that day, and when they were going home. Mel mainly set this expectation for students rather than with the buddy RNs. During her daily rounds, Mel met students in the corridor, asked the RNs if she could take them aside for a short time, and then spent time with them in a tearoom or meeting room. Hence, Mel organised a dedicated time and place away from the corridor and the RNs to make explicit her expectations. All students spent time off the ward with Mel to clarify these expectations (see Chapter 10). Mel also asked buddy RNs when she met them in the corridor, to help the students make a plan for the day but did not go into detail about this with students. For Mel, the corridor was a meeting place for students, buddy RNs and facilitator, and it was an access point to individual learning opportunities to help students know their patients.

Similar to Blue Hospital, Glenda (Red Hospital) wanted students to know their patient and to make a time management plan. However, Glenda expected students to access patient documents and hospital records to ensure they had a good understanding of the patient. Like Mel (Blue Hospital), Glenda used the corridor as a meeting place for students, buddy RN and facilitator to establish her expectations, and as a gateway to individual learning opportunities in quiet spaces for all students. During the two weeks, she met students in the corridor and arranged to take them to the nurses' desk or occasionally to a patient lounge on the ward, in order to go through patient notes or to sign students up to hospital online resources (see Chapter 9 for a detailed description of these activities).

Kim's (Green Hospital) expectation of students during placement was less clear. In the first week, she wanted students to work with their buddy RN in the patient room and do what the buddy told them to do, as well as to seek out any other learning opportunities students heard about. In the second week, Kim wanted them to care for a patient. She seemed to focus on the physical clinical tasks that students needed to do, rather than understanding the information about patients (although it became apparent towards the end of the placement that she was expecting students to read patient notes – see Chapter 9 for details). Kim mainly used the

corridor to meet students and *check in* to see if they had any questions. Follow up with individual student time was more ad hoc in nature and depended on the student asking Kim questions.

Limitations of setting expectations

Setting expectations was important in establishing what it was that students were supposed to learn during the clinical placement. As students spent more time working with the buddy RN than they did with the facilitator, it seems clear that RNs needed to understand these expectations. However, although RNs were sometimes included in conversations about expectations with the facilitator and students, there were limitations to what these corridor conversations could achieve. In planning a patient's care, Glenda wanted students to think about the whole patient, rather than completing a series of atomised tasks delegated to them by the RN. However, due to the ad hoc nature of corridor encounters between facilitator and RNs, and the fact that students might have different buddies each day, not all buddy RNs were clear about Glenda's expectations. Glenda talked to RNs in the corridor if they were present with the students but as Glenda was not able to see all students at the beginning of the shift, she had to rely on students to let the RN know what they could/needed to do.

Furthermore, as mentioned above, the hospital is a workplace and Glenda needed to be mindful that she was making requests of busy healthcare professionals. At times, Glenda was also asking RNs to change their usual practices, as not all nurses wrote the time management plan of care. Some nurses worked with a mental rather than written plan. On the second day, for example, Glenda stood near Ravindra, a student, at the beginning of the shift as he met with his buddy RN, and an Enrolled Nurse (EN). Glenda heard the RN say to Ravindra, 'let's start with obs' (taking vital signs, that is, blood pressure, temperature, pulse and respiratory rate). Glenda asked the RN if they could do a care plan for the day. Before the RN replied, the EN began to talk to the RN about which observations she should do – the EN was also working under the supervision of the RN. Glenda reiterated 'can you show him how you do a care plan'. The RN agreed to show Ravindra how to do a time management plan.

In order to explain the process of making a time management plan, the RN needed to shift the focus away from the *workplace frame*, where the focus was on completing and delegating tasks according to a plan that she may have in her head, to showing the student how to make that plan, that is, shifting to an *education frame.* The use of the term *workplace frame* indicates that the predominant goal was to get the job done. In this frame, the patient care or the routine duties of the workplace were prioritised. The use of the term *education frame* indicates that the predominant goal was the student's learning. Glenda's interventions here are to help students gain access not just to tasks but also to the underlying rationale for those tasks. However, as setting expectations with RNs relied on ad hoc face to face meetings, there were many occurrences where these expectations were not clear to students nor RNs, as discussed in more detail below and in Chapter 9.

Checking in (activity two)

A second activity was *checking in*. There were two types. The first type was a deliberate approach to monitoring the extent to which students were doing what facilitators expected them to do. In Red Hospital, as noted above, that was reading patient notes to make a time management plan; and in Blue Hospital it was knowing the patient they were caring for by understanding the handover sheet. The second type of *checking in* was an ad hoc approach, where Kim, during her daily rounds of the ward, asked students if they had any questions. If they responded with questions, it often resulted in follow up learning opportunities. If they did not have any questions, Kim moved on to the next student.

A deliberate approach to checking in: monitoring expectations in Red and Blue Hospitals

In Blue Hospital, Mel monitored students' performance by asking them who their patient was when she *checked in* with them as she did her daily rounds. Students used the handover sheet to provide information about the patients. On one or two occasions, if students did not seem to know their patient, Mel directed them to a space where they could spend time talking about the patient's medical conditions. However, this was not a regular occurrence and Mel mainly monitored

expectations during the *end of day debrief* where students had to demonstrate their knowledge of their patients (see Chapter 10).

Glenda's corridor interactions in *checking in* with students were focused on monitoring her expectation that students had planned care of a patient. She asked students directly if they had made a plan and if they hadn't directed them to another space where she spent time with them focusing on reading notes and planning care (discussed in detail in Chapter 9). In this way, the corridor was a gateway to other learning spaces but Glenda directed students to these spaces. In these spaces, usually at the **nurses' desk** or in a **patient lounge**, she provided students with opportunities to become familiar with the documents and records they needed for the care planning process.

In using the corridor as a space to monitor performance, Glenda was able to withdraw from the *workplace frame* students who were not meeting her expectations and provide them with additional guidance within an *education frame*. Glenda was in control here of the corridor as an entry point to this *education frame.* She initiated the interactions with students and set up the activities. As she walked around the corridors she wrote notes in her notepad, deliberately monitoring which students had spent dedicated time with her to look at the information systems and documents related to their patients. As indicated in Table 12 below, in week two, Glenda spent intensive time with three students: Ryoko, Mingxia and Ravindra, when she noticed that they had not been making a plan of care for their patients. Table 12 shows what she did with each student in the corridor and whether there was a 'follow on' activity in a different space.

Table 12: Monitoring expectations in the corridor

Red Hospital	**Monitoring expectations**	**Follow up**
Day 1		
Day 2	Mingxia and Soo-jin: query plan	
Day 3	Ravindra: query plan	
Day 4	Mingxia: query	Follow up session on patient notes at the desk and in a patient lounge
Day 6	Ravindra: query plan	Follow up session on patient notes at the desk
Day 7	Mingxia: query reading notes	Follow up session on patient notes at the desk and in a patient lounge
Day 8	Ryoko: query plan	Follow up at desk to make a plan

The extract below from my field notes on the fourth day, illustrates how Glenda deliberately directed students to other spaces for learning.

> Glenda walks around the corridor and notices Mingxia standing near the desk. Glenda asks Mingxia if she has a care plan for her patient. Other nurses are standing and sitting behind the desk, some looking at computer screens and some talking together. Mingxia replies that she is not sure and she will choose a patient later. Glenda says to Mingxia that they will do it now, that she will look at notes now with Mingxia and set up a plan of care. Glenda asks Mingxia who her buddy nurse is. Mingxia tells Glenda and Glenda approaches the RN who is doing something at the desk and asks if she minds if Mingxia makes a care plan with Glenda about a patient. Glenda and Mingxia go into the small room behind the desk where the notes are kept in pigeonholes. There are probably about 50 different forms. Mingxia is looking for a blank nursing care plan

> …Glenda and Mingxia go to the small patient lounge on the ward to read notes - it turns into a long session.

Glenda here notices that Mingxia appears to be not planning care; asks her directly if she has a plan; arranges for her to leave the *workplace frame* by requesting permission from the buddy RN; and spends follow up time with Mingxia in a dedicated *education frame*.

This monitoring of expectations seemed important, as although Glenda explicitly told students to plan care and to read notes, as became apparent in week two, many were not doing that. It seems that the expectations were not clear for students nor for RNs. In stressing the importance of planning care, Glenda is acting as an expert clinician who knows how to plan patient care. She is also acting as an expert educator, teaching students the 'correct' way to plan care, making sure students learn how to prioritise patient care and can move beyond completing a list of skills, such as taking blood pressure. She is in this role an 'expert' of the broader community of practice of the nursing profession. However, she is also an outsider to the local community of practice of the ward and may be seen to be challenging the RNs usual way of doing things. Glenda seemed to acknowledge this in the way she formed her requests to RNs. For example, on the second day, Glenda asked a buddy nurse in an indirect and quite casual way 'if you can show her how you do your day so she can see how you prioritise your shift', not emphasising how important Glenda considered planning of care. Likewise, Glenda's instruction to students regarding the care plans were also sometimes slipped in to conversations and often couched indirectly as suggestions. On the first day, for example, in a session with Emma, (a student for whom English is a first language) that had been focusing on reading patient notes, Glenda said towards the end of the session 'what I'm suggesting to you is ideally you should be reading the notes the day before' … 'if you can each day choose one of your patients'. However, it became clear throughout the week that planning care by looking at documentation was Glenda's expectation. In her debrief sessions, Glenda used a more direct manner in explaining her expectation; it was to choose one patient per day, read the bedside and progress notes, and plan care.

Glenda's indirect instructions with the nurses may have been a way of managing her position as an outsider on the ward, recognising the potential power differentials. Her use of indirect instructions may not have been explicit enough for students, and particularly for EAL students. Nevertheless, in using the corridor to monitor student performance, Glenda was able to see what students were doing, ask if they had planned care and to follow up if they had not. Glenda's use of the corridor as a gateway to the nurses' desk or other spaces where the *education frame* could be foregrounded provided access to opportunities for all students to become familiar with hospital documentation. The second type of checking in activity described below did not offer the same opportunities to all students.

An ad hoc approach to checking in: responding to student questions in Green Hospital

The second type of *checking in* was mainly used in Green Hospital, where Kim walked around the wards several times a day and, as she met students in the corridor, or in doorways to the patient room, asked them if they had 'any questions' or 'what's happening'. This section will focus on how Kim *checked in* with students and, in particular, how this approach helped some students gain entry to learning activities with the facilitator in the corridor and in other spaces, but limited opportunities for other students. It compares two students' experiences, Jing and Angie.

Kim visited students on the wards after 7.30 am when they had finished attending handover and were already working with a buddy RN and a patient allocation. As Kim walked through the corridors, she stopped students and asked if they had any questions. Very occasionally, students initiated interactions with Kim. Usually the interactions involved students and facilitators, and occasionally the buddy RN. Whereas the goal of *checking in* in Blue and Red Hospitals was to *monitor students' performance* in terms of meeting expectations (as discussed above) Kim's goal in Green Hospital, seemed to be to 'look after students' in terms of ensuring there were no problems and responding to any questions students raised. On the third day, Kim said to me after she has been talking to a couple of students 'I'm like a babysitter', I'm just making sure they're okay'.

Checking in activities could proceed in three different ways: firstly, if students had no questions, there was usually no more talk and Kim moved on; secondly, if students asked questions or 'told troubles', Kim sometimes remained with the student in the corridor, and responded to their questions; finally, in response to some questions, Kim directed students to another space to talk in a quieter environment, for example, a tea room, or to access resources, which were mainly located at the nurses' desk.

The focal themes of these corridor interactions centred on clinical themes and topics related to student learning and assessment. Occasionally, students 'told troubles' about difficulties they were facing. Students asked questions about medications, patients' conditions, hygiene precautions, and terminology. They also asked questions about the clinical assessment forms, their scope of practice (for example, whether they were allowed to administer medication), and advice about how to learn on clinical placement, particularly how to learn the names of medications. The responses by students to Kim's 'what's happening' focused on students reporting what they were currently doing, or 'troubles telling'. When 'telling troubles', students expressed concerns about patients with psychiatric conditions, deteriorating patients, and death. They also focused on problems they were encountering; one student talked about the difficult relationship she had with the RNs and sexually inappropriate behaviour by a patient. Reports on students' activities could result in Kim accompanying them to the patient room to observe or work alongside them (see Chapter 7). Questions about patients or medications could result in Kim accompanying students to the nurses' desk to access patient notes and online resources.

An ad hoc approach: unequal learning opportunities

Most noticeable about Kim's *checking in* activities is that some students gained entry to learning opportunities both in the corridor and elsewhere, whereas other students seemed not to get these same opportunities. What struck me in week one, as I walked around the wards with Kim on her daily rounds, was the amount of time that one of the nursing students, Jing, spent with the clinical facilitator, Kim, in comparison to other students, and in particular in comparison to Angie. In

terms of the amount of time spent with students, Jing and Angie had respectively the most and the least amount of time with Kim. Both Angie and Jing were EAL students. Table 13 (below) shows the number of interactions that each student had with the facilitator throughout the placement. It also shows whether the initial interaction in the corridor resulted in them moving to a 'follow on' activity in a different space. It can be seen in Table 13 that Jing had more corridor interactions and more follow-on movement to other spaces and activities than did Angie. On multiple occasions, Angie said she was busy and that she would ask questions later (whether she did or not is discussed later in this chapter and elsewhere). In contrast, Jing nearly always had questions to ask or something to talk about in terms of patients and what she had been doing.

Table 13: An ad hoc approach to checking in: unequal learning opportunities in Green Hospital

Key: ** indicates when the interactions were initiated by students (Days 10 and 4)				
Day	**JING**	**Follow on**	**ANGIE**	**Follow on**
1			Asks about Assessment	**NONE**
3	Asks how to prioritise and plan care			
	Asks about patient condition	Nurses' desk		
4	Tells troubles about a patient		No questions: Angie says she is busy	
	**Patient condition	Nurses' desk	No questions: Angie says she is busy	
5	Follow on troubles telling about patient from Day 4		No questions: Angie says she is busy	
			Asks about assessment	
7	Asks about patient condition	Nurses' desk		
9	Asks about patient condition	Nurses' desk		
10	**Asks about patient condition	Quiet space in the corridor sitting at low table	No questions	
	Asks about patient condition	Nurses' desk	No questions	

Ad hoc approaches reported in the medical literature have been reported to be a valuable way of teaching (Morrison et al. 2014; Pearce 2003). Usually the junior doctors initiate the questions and the responses help them solve immediate uncertainties they are dealing with in patient care. These interactions can be described as just-in-time learning. However, unlike the ad hoc interactions

reported in the medical literature, here Kim, the facilitator, usually initiates the interactions. However, her use of open questions, 'any questions' or 'what's happening' means students need to choose the topic and take the time to interact with her. When Kim saw students, they were sometimes busy walking between the patient room and the equipment room to collect a piece of equipment, or they were walking between two patient rooms on their way to complete a clinical task with a patient, sometimes with their buddy RN. They were, in other words working on the ward as novice student nurses; they were operating in a *workplace frame*. In order to respond to Kim with a question, they had to take time out of their tasks and make time to stand with Kim. Kim's open question meant students could opt into the *education frame* of clinical placement, by spending time with their facilitator talking about what they had not understood at handover, or asking about medical conditions or their own assessment, or they could choose not to opt in and remain in the *workplace frame* where their priority was to work with the buddy RN.

Kim's use of an open question contrasts with the focused, closed questions used in *monitoring expectations* described above, where students were asked to respond to specific topics. In addition to the question, movement may also have played a role. Kim walked quickly through the corridors, and spoke quickly. There was a sense that she was 'on the move'. When students responded, she stopped and paused with them but if students did not respond, she often quickly moved on. In contrast, in monitoring expectations, Mel took students aside to another space, away from the buddy RN and patients. Glenda tended to *check in* with students when they were standing near the desk in the corridor. She also moved slowly and spoke slowly and there was a sense that she had time to spend with students. She regularly took them to other spaces.

The extract from my field notes below illustrates how a student's question resulted in more time with the facilitator.

Day Three. Green Hospital.

> Jing [student] approaches Kim [facilitator] in the corridor and says there's a patient where they need to wear gloves and gown but she's not sure why. Kim says let's go and get the MIMS [drug manual]- do you know where that is. Jing says she thinks it is at the desk. They walk to the desk, get the MIMS and sit at the desk going through the information in the MIMS… Kim then finds the patient notes and takes Jing to the patient room where gloves and gown are required and they stand in the corridor and look at the warning sign on the door and look at the patient notes. They sit down at a small table in the corridor outside the patient room. This room is at the end of the ward, in a private space and the table creates a small space that feels like an alcove. Jing and Kim spend more than 20 minutes here.

During sessions like the one described above, Jing learned the meanings of specific nursing terms and how to use them; how patient notes were structured and how to read them (see Chapter 9 for detailed discussion about what students learned when reading notes). Gaining Kim's attention was the first step towards spending individual time with her. The extract above illustrates how Jing and Kim's use of the corridor gave Jing access to learning opportunities that were 'just in time'. Kim moved between different spaces to respond to Jing's query: the corridor was a gateway to other spaces: the desk, the patient room and a space they repurposed in the corridor where they could sit and look at notes.

However, in order to benefit from this ad hoc approach, students needed to be confident to ask questions, to be able to identify their learning goals, and to negotiate relationships with the RN and clinical facilitator. Jing was the only student who excelled in using the *ad hoc checking in* used in Green Hospital. Jing was able to exploit Kim's ad hoc approach to facilitation by noticing what she wanted to find out, and following up her questions by drawing on the knowledge of the experts available including her buddy RN but also other RNs and, in particular, the clinical facilitator.

Compared to Jing, Angie did not have much individual time with Kim. Although Kim approached Angie in the corridor and asked her 'any questions', Angie said 'later'. By deferring the questions to later, Angie missed out on learning opportunities, as there was not always a later opportunity to ask questions. In her previous clinical placement, Angie had participated in a debriefing session at the end of each day and this was something she was expecting to happen on this placement. For Angie, the debriefing session had been an opportunity to meet as a group of students with the clinical facilitator at the end of the day away from the ward, and a place where she could ask questions. Angie did ask questions during the debriefing sessions in placement I observed (see Chapter 10). However, there were only four debrief sessions

By the third day, I had noticed that Angie did not seem comfortable asking questions when Kim visited her on the daily rounds. In a conversation with Angie in the tearoom over lunch, she told me that the debrief session was a good opportunity to ask questions and it was not always possible or convenient to ask Kim when she came because if the student was in the middle of doing something she could not leave it half-finished to talk to Kim. Kim had also noticed that Angie was nervous when she was around and had therefore decided to leave her alone as she could see she was a 'good nurse', that is she was 'completing tasks' and 'talking to the patients'. However, as a result of the *ad hoc checking* in approach, Angie did not have many learning opportunities with Kim. Angie told me she wrote down a lot of words each day that she did not understand; these were the words she would have liked to ask Kim in the debrief.

One explanation for the different styles of interaction could be that Angie was not as confident a speaker of English as was Jing. However, it seems it was more that Angie found it difficult to step in and out of an *education* and *workplace* frame in the corridor. In the three debrief sessions away from the ward, Angie asked many questions and participated in discussion when possible (see Chapter 10). However, whereas Jing seemed to prioritise her own learning, Angie seemed to prioritise managing the relationships with the RN. Angie told me that one of the reasons she did not ask questions was her concern at offending her buddy RN. She

felt that if she asked the clinical facilitator questions the RN might have been offended, as the RN was her teacher and might wonder why Angie was not asking her the questions.

Whereas previous research often focuses on the role of the 'expert other' in scaffolding learning for more novice practitioners, these extracts illustrate the role of the novice in initiating and engaging in these interactions – or choosing not to engage. Jing, here, although a novice nurse, was instrumental in initiating and exploiting these pedagogic interactions. What seemed to help Jing exploit Kim's approach was her high sense of agency as a learner. Jing made a point of finding out about the medical conditions not only of the patients she was caring for but of other patients she noticed, who had serious medical conditions, and that she thought were 'interesting'. She used Kim as an 'expert resource' to explain conditions or situations she did not understand. She foregrounded her role as a learner; she often took control of the opening and closing of the interactions, and reminded Kim if she had arranged to do something with her. After talking with Kim individually in a space away from her patients, either in the corridor or at the desk, Jing signalled when she wanted to finish an interaction, using phrases such as 'I'd better go and see what my RN wants me to do, I'll see you guys later' or 'ok I'll go back to my RN now'.

In an interview with Jing, she recounted how she 'took charge of her learning', by noticing, finding out and sometimes trying things out. She was persistent in her search for an answer, asking various experts until she found what she was looking for. Some of the things she noticed included how expert practitioners, that is the RNs she worked with, prioritised and planned care; safety procedures associated with particular medical conditions or names of medications. According to Jing, she had learned to take charge of her learning during her previous study in Australia. She had already completed an undergraduate degree in another area as well as undertaking further studies at university. Furthermore, she was generally confident with English language. She had already achieved the required English language score for registration as a nurse. In these ways, Jing was the exception amongst the EAL students I observed.

Pedagogy on the move: providing access to learning opportunities

The findings presented in this chapter show that the corridor is a space that facilitators can use to get a bird's eye view of what is happening on the ward and can be used by facilitators to assist students in gaining entry to the workplace, that is the local community of practice of the ward. Specifically, facilitators can help students establish buddies, choose patients, and clarify expectations with RNs and students. It is also a space where facilitators *check in* and where students can gain access to other spaces on the ward that provide differing learning, and language socialisation opportunities. However, these findings also show that there are disparate practices amongst facilitators in using the corridor and that pedagogy that is 'on the move' as facilitators walk around corridors on their daily rounds, can both extend and constrain students' learning opportunities. The corridor is a space where the *workplace* and *education* frames sit alongside each other and an ad hoc approach to *checking* in that relies on student responses to gain access to other learning spaces can result in unequal learning opportunities. Similarly, an ad hoc approach to *setting expectations* with RNs may also result in a lack of clarity about what those expectations are for students. This lack of clarity between facilitators and buddies confirms previous research that has called for closer cooperation between the two parties (Mattila, Pitkäjärvi & Eriksson 2010; Rogan et al. 2006).

As noted in Chapter 1, the importance of the interpersonal relationship between students and supervisors in the medical field has been emphasised (Kilminster & Jolly 2000), and similarly research into EAL students' experiences during clinical placement has concluded that the interpersonal relationship students have with the facilitator greatly affects the students clinical experience. It has been found and that friendly facilitators and welcoming staff result in positive experiences for students (Eyre 2010; Jeong 2016). My study, however, demonstrates that being friendly is not enough. Kim was a friendly facilitator who welcomed students, and who aligned herself with students in various ways, for example, when one of the students said she did not know the names of all the dressings, Kim said she found it hard too. Kim was also inclusive in her approach to teaching and in how she

expected students to behave, acknowledging that not all nurses talked to patients socially, and that there were many different kinds of nurses.

Nevertheless, despite Kim's friendliness and her inclusive approach, some students, most notably Angie, had limited learning opportunities. In a review of previous literature on EAL students' clinical experiences, Mikkonen et al. (2016a, p. 173) found that EAL students can find the process of integrating into the workplace stressful and argues that students need time and 'well prepared pedagogical orientation' to help them integrate. The findings presented in this chapter illustrate a pedagogic approach and activities that can be used in the workplace to help students integrate to the clinical ward.

In a significant body of work that investigated undergraduate nursing students' clinical experiences in the UK, but that was not focused on EAL students, Spouse (2001) also noted the challenge for students in entering the workplace. She found that students were often seen as members of the workforce rather than learners. This tension between being workers and learners appears in literature on both EAL and non-EAL student experiences (Spouse 2001; White 2010). Spouse (2001, p. 518) states that students are often seen as members of the workforce and concluded that important factors that helped students transition to practice included the mentor 'befriending' students, and the mentor assessing and planning learning by helping students organise learning opportunities and select patients. The *setting up the shift: setting expectations* and *checking in: monitoring expectations* are examples of facilitators planning students' learning in the broadest sense. According to Billett (2011, p. 23) 'educational processes are supposed to be intentional, guided by purposes that are considered, and informed by the kinds of goals to be achieved and the kinds of learning that are supposed to arise from them'. In my study, Glenda and Mel took a more planned approach than did Kim, and wove these intentional educational processes into the workplace.

In Spouse's (2001) study, students were supervised by mentors who were also working as nurses on the ward, not facilitators (as discussed in Chapter 3). Spouse interpreted their role as that of sponsoring students into the community of

practice (Lave and Wenger 1991). In my study, Glenda, Red Hospital, and to some extent, Mel in Blue Hospital, played a similar role to the mentors in *setting up the shift*, but rather than being a sponsor into the local community of practice of the ward, facilitators acted more as brokers. In *setting up the shift*, facilitators were operating predominantly in an *education frame*. The sponsorship role into the community of practice was mainly played by the RN in the *workplace* frame. The RNs allocated tasks for students and worked alongside them throughout the day. However, the buddy RNs in my study were usually not familiar with the university curriculum, nor the students' clinical assessment forms. By undertaking the activities *setting up the shift* and *setting expectations,* facilitators were helping establish favourable conditions, whereby buddy RNs could act as sponsors in helping students focus on the care of one patient, and demonstrating how to make time management plans. For this process to occur befriending (Spouse 2001) was not enough. *Setting expectations* was a way of promoting students as learners and not just part of the workforce. By focusing on what students should be learning, and by including buddy RNs in this expectation, the role of students shifted from a 'helper' carrying out a series of tasks, to a student who was learning key practices of nursing, that is understanding the patient, and understanding the processes of planning care. The facilitator's role in deliberately monitoring these expectations gave students access to spaces where they could step away from the *workplace* frame and have dedicated learning time with the facilitator.

Whilst *setting up the shift* went some way towards helping students enter the local community of practice, the 'on the move' approach, which relied on ad hoc meetings with buddy RNs to set up these expectations, was also limiting. Not all buddy RNs interacted with the facilitators (that would not be possible given the change of staff with shift rosters and the limited time of facilitators). The indirect ways in which Glenda expressed the expectations and her wish for RNs to carry out activities with students also illustrate the potential tensions between the *education* frame in which facilitators operate and the *workplace* frame in which the RNs predominantly operate. The diversity of expectations amongst the three facilitators in this study also suggest a need for more explicit guidelines from the university in terms of what should be expected from students. Whilst some students may be able to navigate the processes of buddy and patient allocation,

and establish and monitor their learning themselves, the majority of EAL students I observed benefited from guidance in these processes. Jing was the exception in being an 'agentic learner' in the corridor, that is a learner who is 'active, directed and intentional' (Billett 2011, p. 28).

The role of student agency in learning is referred to implicitly in studies of the clinical experiences of nursing students. As noted in Chapter 2, clinical facilitators appreciate students who are willing to learn and who show initiative (San Miguel & Rogan 2012). EAL students in particular are often reported to not show initiative or have difficulties in adopting a self-inquiry learning style because of cultural values based on respect and learning styles (Brown 2005; Eyre 2010; Malau-Aduli 2011). However, as can be seen with Angie, in the findings in this study, it was not that Angie did not have any agency, nor that she did not have any questions to ask but rather her agency was constrained by the space, the coexistence of a *workplace* and *education* frame, the relationships existing with each of those frames, and by the pedagogic approach of the facilitator. The competing *education* and *workplace* frames made it challenging for some students to adapt to an approach that required them to take time out of the *workplace* frame to focus on *education*. In other spaces where the *education* frame was prioritised, for example during the end-of-day, Angie asked questions.

Studies in second language research draw on a construct of 'willingness to communicate' to discuss participation by EAL learners. Rather than being an individual character trait, it is a dynamic construct dependent on individual and environmental factors (Peng 2012). Nursing students, particularly Asian students, can be perceived by some facilitators as 'quiet' and 'lacking initiative' (San Miguel & Rogan 2012). However, my study demonstrates that the pedagogic approach of facilitators as well as a combination of individual, social, and physical factors affect students' willingness to communicate. In attributing Angie's reluctance to ask questions to Angie's state of being nervous, Kim was sensitive to Angie's feelings and perhaps helped Angie in the short term by avoiding the discomfort of talking to the facilitator in front of her RN. However, had Kim taken a more direct and deliberate approach to *checking in* with Angie, and taken her aside to as space

where she could privilege the *education frame*, Angie may have gained more learning opportunities.

Facilitators influence students' access to learning opportunities and the events that those opportunities offer. In particular, how facilitators use the corridor as an entry point to other spaces in the hospital provides access to or constrains opportunities students have for learning and for communication with the facilitator. While both Jing and Angie passed the clinical placement and both received the same assessment in terms of their level of English language, Jing's view of the clinical placement was far more positive and enthusiastic than was Angie's. Jing had a 'fabulous' clinical placement, whereas Angie felt that she 'did not have much to do'. Whereas Jing's sense of agency enabled her to 'grab opportunities', Angie, although acknowledging that the facilitator was friendly and wanted them to ask questions, preferred to be given more direction and may have benefited from a more deliberate approach to spending individual time with the facilitator like that adopted by Glenda.

The time students gained with the clinical facilitator may be particularly important for EAL students who may take longer to adapt to the clinical environment. When away from patients and RNs, students could ask questions in relatively quiet environments without competing with the need to achieve and complete clinical tasks at the same time.

Conclusion

This chapter illustrates how the facilitator's pedagogic approach plays a key role in extending or constraining learning opportunities for students both within and outside of the *workplace* frame. Students can gain entry to the workplace in a way that provides learning opportunities; or they can be left to find their own way into the workplace and risk, like Angie, remaining in the same patient room, with limited learning opportunities. Similarly, facilitators can *monitor* students' performance, check whether they are *meeting expectations*, and deliberately direct them to other learning spaces where they can work within an *education* frame to guide them in meeting those expectations. Or facilitators can use a

pedagogic approach that is less deliberate, which can result in unequal learning opportunities.

The findings presented in this chapter also show that there is no one way that suits all students, and in particular that not all EAL students will learn and respond to the facilitator in the same way, merely because they may share cultural heritage. An awareness of different pedagogic approaches and their potential effects on students' learning means facilitators can adjust the approach to best extend students' learning opportunities. For students like Jing, who already have experience in an education system where she had learned to be a self-directed learner, and who was confident with her English language ability, a less guided (or ad hoc approach) offered her opportunities to seek out her own learning goals and pursue them. However, for the majority of novice EAL students in my study, a deliberate approach to helping them gain entry to the workforce and to other learning spaces was beneficial. This approach includes using the corridor to *set up the shift* by assisting in the process of selecting buddies and patients and clarifying expectations; and *checking in* to *monitor those expectations*. It also involves facilitators intentionally selecting opportunities to withdraw students to other spaces to ensure they can access resources to fulfil the expectations. Such an approach provides access to learning opportunities for all students. This deliberate approach also gave facilitators opportunities to spend time with all students, which in turn enabled them to make assessments of their nursing skills, including their communication skills in English. The following chapters discuss these spaces and the learning opportunities in each space.

Chapter 7 - Patient Room: practising nursing

Supervising students as they carry out patient care activities has been acknowledged as an essential part of healthcare education. In medical education, this kind of supervision has been referred to as 'supervision on the job' (Kilminster & Jolly 2000), 'bedside teaching' (Peters & ten Cate 2014; Qureshi 2014; Qureshi & Maxwell 2012) and 'hands on' supervision (Iedema et al. 2010). However, in nursing education, there is no commonly used term for this kind of supervision and whilst its importance has been acknowledged, there has been little research into what occurs when clinical facilitators work with students in patient rooms. This chapter analyses the kind of activities that occurred between EAL students, their facilitator, the patient, and sometimes the buddy RN in the patient room. In this study, I am using 'bedside teaching' to refer to the activities *observing bedside interactions* and *working alongside,* as it is a term already used in the medical literature, and emphasises the patient in the bed as central to the activities.

The importance of the role of facilitators in working with students and guiding their learning in patient care has been widely acknowledged. Studies of students drawing mainly on interviews, diaries and focus groups, rather than observation of interactions in the patient room, report that facilitators guide students' learning in developing clinical competency (Henderson et al. 2010): for example, undertaking an electrocardiogram (ECG) (Henderson & Tyler 2011) administering medication (Valdez, de Guzman & Escolar-Chua 2013); and helping students undertake tasks that are currently beyond their skill level (Spouse 1998b). None of these studies focused on EAL students. Similarly, in the medical literature, the main focus of bedside teaching seems to be on developing clinical skills, in particular making a diagnosis.

Studies of bedside teaching draw mainly on the concept of learning through participation and argue that patient care provides students with opportunities to learn with an expert close at hand (Bourgeois, Drayton & Brown 2011; Spouse 2001), through role modelling, demonstration, and direct feedback (Henderson et al. 2010). One of the few studies that drew on actual interaction between patients,

students and supervisors was in the field of GP education (Ajjawi, Rees & Monrouxe 2015). It found that bedside encounters between medical students, GP supervisors, and patients focus on both patient care activities and on student education. Ajjawi, Rees and Monrouxe (2015) argue that the GP clinic is a complex learning environment and the way in which supervisors juggle patient care and student education enables or constrains opportunities for participation. In my study, the learning environment of the patient room is even more complex in terms of the relationships between participants, the physical and mental complexity of movement and interruptions during interactions, the linguistic diversity of students and patients, and the novice status of students.

It has also been argued that bedside teaching is important in learning to communicate effectively with patients (Peters & ten Cate 2014); to observe and learn patient centred care (Qureshi 2014); and to manage the challenge of time while still building patient rapport (Qureshi & Maxwell 2012). There are, however, few studies that investigate whether and how supervisors help students develop communication at the bedside. One way of beginning to build rapport with patients is through small talk (Coupland 2000; Spiers 2002), which serves to build and maintain positive social relationships (Holmes 2003). Rapport between nurses and patients is foundational to forming therapeutic relationships, which constitutes one of the Australian standards of nursing (NMBA 2016), and experienced nurses have been found to use small talk extensively in their daily work (Holmes & Major 2002; 2003). In nursing, small talk belongs to the realm of professional discourse (Shrubshall & Roberts 2005), part of the shared repertoire of the nursing profession. In particular, the importance of small talk in nurse-patient interactions during routine clinical procedures was noted by Major and Holmes (2008). One of the few studies analysing nurse-patient interactions in hospitals found that when carrying out procedures, there were typical components in the interactions between nurses and patients, although there was no fixed order of components, nor were all components always included. The one core component present in the 23 interactions studied was a description of the clinical procedure being undertaken. Eight of the 23 interactions studied were what Major and Holmes (2008) call concurrent procedures - the least complex of

those studied, for example, taking blood pressure. It was found that in the less complex concurrent procedures, nurses included small talk on topics like the weather, the patient's family and the nurse's social activities; and that nurses thought this small talk was important to establish rapport. Similarly, a study of nurse practitioners working in patients' homes (Defibaugh 2014) found that nurses' small talk with patients seemed to reduce the social distance between participants and make patients more comfortable about talking about themselves.

Two recent studies have investigated the use of small talk by EAL RNs to build rapport with patients (Crawford, Roger & Candlin 2017, 2017a). Crawford, Roger and Candlin (2017) compared the performance of an RN who had ten years of nursing experience in Australia with an RN with three years of postgraduate experience. Similar to the nurses in Major and Holmes (2008), the EAL RNs established rapport with patients by using small talk and humour. However, the RN with more nursing experience demonstrated a higher level of communicative expertise. The authors conclude that this expertise can partly be attributed to her having been socialised into the nursing discourse during her extensive work experience in Australia. The lesser expertise of the more recently qualified RN indicates how challenging building rapport could be for novice EAL students with little nursing experience and minimal time spent being socialised into the language of nursing.

Making small talk in a new environment can be particularly challenging for EAL students. One of the few studies of EAL nursing students which included field observations found that students initiated few conversations with patients, instead tending to ask only formal clinical questions, and using checklists exactly as they were written (Brown 2005). Similarly, EAL students participating in a language programme as part of their undergraduate nursing studies in New Zealand were surprised at the amount of personal information exchanged between nurses and patients in authentic transcripts used as teaching resources (Malthus, Holmes & Major 2005). Some students felt that the topics of conversation, such as the kind of clothes they liked to wear and details about patients' personal relationships with their visitors, were too intimate for nurse-patient interaction. Other students have

reported not knowing what kinds of topics they can talk about to make small talk with patients (San Miguel & Rogan 2009). However, little is known about what opportunities are created for students to develop small talk in the clinical placement. In my study, bedside encounters were the only activities (when the facilitator was present) where there were regular opportunities for students to make small talk with patients. This chapter explores how bedside teaching provided access to opportunities to learn both clinical and communication skills, including making small talk with patients.

As described in Chapter 6, students were allocated to patient rooms at the beginning of the shift and spent the rest of the day working with their buddy RN and allocated patients. Overall the pedagogic approach for gaining access to the patient room was planned, in that facilitators were expected to watch students complete particular activities. However, it was unscheduled for time as facilitators had to take opportunities to fit in with whatever routines and practices students were engaged in independently or with their buddies. Usually facilitators used the activities that students were about to do, or needed to do, as opportunities to observe and work with students, rather than arranging for students to undertake specific activities for teaching purposes. During their daily rounds, facilitators either looked into patient rooms for opportunities to observe or work alongside students, or met students in the corridor and accompanied them to the patient room. Only occasionally did facilitators arrange to meet students at designated times, in order to observe skills listed on the clinical assessment form, usually those of taking vital signs (blood pressure, temperature, pulse, oxygen level), or monitoring a patient's blood sugar level (BSL).

Activities in the patient room

The activities that took place in the patient room, the focal themes of these activities, and the tasks students completed during these activities are summarised in Table 14 below.

Table 14: Activities and focal themes in the patient room

ACTIVITY	FOCAL THEMES		TASKS
Observing bedside interactions Facilitators *observe* students with patients	**Clinical skills**	Physical skills	Taking vital signs Changing dressings Collecting urinalysis
		Communication	Asking about pain Giving instructions Talking to patients who did not speak English
	Safe practice	Physical skills	Performing hand hygiene Using contact precautions Using correct equipment
Working alongside Facilitators *work with* students undertaking patient care	**Clinical skills**	Physical skills	Mobilising patients Repositioning patients Showering patients Doing ECGs
		Communication	Giving instructions
	Safe practice	Physical procedures	Tidying around beds
		Communication	Reporting results to RNs
Demonstrating how Facilitators demonstrate to students	**Clinical skills**	Physical skills	Doing an ECG
Talking about patients Facilitators *talk* with students (no patients involved)	**Clinical themes**		Discussing patient care Telling troubles Handing over patients: (practice and actual bedside handovers)
	Student themes		Asking about assessment

The first two activities, *observing bedside interactions* and *working alongside* usually involved the patient, whereas the last two, *demonstrating how* and *talking about patients* usually occurred when the patient was not present. This chapter focuses on *observing* and *working alongside*, as they were ones that most created opportunities for students to participate in patient care where the patient was also present.

Observing bedside interactions (activity one): assessing physical skills rather than communication

As noted in Chapter 5, *observing bedside interactions* describes activities where the facilitator tended to stand back from the bedside, either to one side or the end of the bed, and allowed the student to lead the activity. The focus of these activities was completing routine clinical skills that were listed as assessment items on the students' clinical assessment forms, for example, taking vital signs or a blood sugar level reading (a BSL). In Table 15 below, it can be seen that Glenda, Red Hospital, and Kim, Green Hospital, observed all EAL students as they undertook patient care, whereas Mel, Blue Hospital, spent less time in the patient room. What is noticeable about Glenda's observations is that she consistently followed up the patient room interaction with time spent elsewhere, usually in the corridor, where she talked with students about the interactions she had observed.

Table 15: Observing bedside interactions in the patient room: record of activities

Red (Glenda)	**Observing students**		**Follow up reflection elsewhere**
Day 1	Ryoko	Vital signs	Corridor
	Soo-jin	Vital signs	Corridor
Day 2	Ryoko x 2	Vital signs: respiration	Corridor
Day 3	Ravindra & Hua	BSL	Corridor
	Ravindra	Urine bag disposal	Equipment room
Day 7	Ravindra & Hua	Vital signs	Corridor
	Ravindra	Vital signs & contact precautions	Corridor
	Ryoko	Vital signs	Corridor
Day 8	Ryoko	Mobilising patient; contact precautions	Corridor
	Hua	Vital signs	Corridor
	Soo-jin	Vital signs	Corridor
	Mingxia	Vital signs	Corridor
Green (Kim)	**Observing students**		**Follow up reflection elsewhere**
Day 1	Hongyan:	Explaining care to patient who did not speak English	NONE
Day 3	Hongyan:	Providing breakfast	
	Jing:	Vital signs	
Day 5	Hongyan:	Vital signs	
	Priya:	BSL	
	Maymei:	Vital signs	
Day 6	Angie:	Preop checklist; wound dressing	
Day 8	Jing: BSL;	Preparing for shower; urinalysis	
	Priya;	Vital signs	
Day 9	Nisha:	Vital signs; feeding	
	Claire:	Vital signs; feeding	
Day 10	Maymei:	Vital signs	
	Hongyan:	Feeding	
Blue (Mel)	**Observing students**		**Follow up reflection elsewhere**
Day 5	Liming:	Handover with team members	NONE
Day 6	Mouy:	Exceeding scope of practice	A quiet space: the store room

The two extracts below illustrate how facilitators, patients, EAL students and the researcher interacted with each other at the bedside. Both extracts demonstrate how facilitators focused on making sure the patient care activity was completed safely by giving feedback to students at the bedside. Both extracts also demonstrate how students had to participate across multiple frames, interacting with their facilitator as a student, and interacting with the patient as a nurse. Finally, both extracts demonstrate how students could use minimal talk when undertaking clinical tasks with patients.

In these extracts the dialogue has been reconstructed from my field notes (Stoller & Olkes 2013). Ethics approval for this study did not include audio recording of patients interacting with students and facilitators so I took field notes at the bedside, which included writing down verbatim, where possible, the student comments in particular. I have used my field notes to reconstruct dialogues to give a better picture of the interaction. However, there are no transcription marks, as I did not note details of the interaction, for example, silences, or overlaps, in my field notes.

Observing bedside interactions: managing multiple frames in a multilingual patient room

Setting and access

The setting for this extract is a patient room with four beds. Kim, the facilitator met Jing in the corridor during her daily rounds, discovered that she was about to take vital signs and accompanied her to the patient room. Figure 6 shows where Kim stood in this interaction, which is away from the patient and next to an empty bed, approximately three metres away from Jing and the patient interaction.

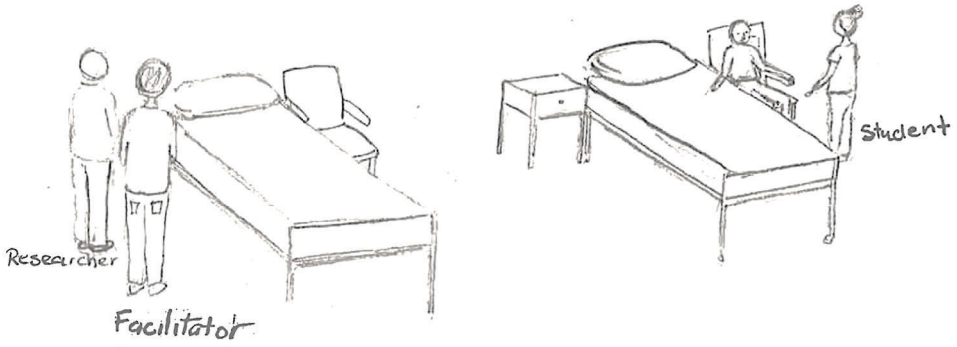


Figure 6: Observing Jing in the patient room

The patient was a Cantonese speaking elderly man who could not speak English. The student was a speaker of Mandarin, but not Cantonese. In the spoken form, these two languages are very different from each other. Earlier that day, the RN had asked Jing to come and help with the patient, and Jing had managed to interact with him using a few words of Mandarin that the patient was able to understand. Multilingual interactions between staff and patients were not uncommon during my fieldwork, as has been found in other studies (Duff, Wong & Early 2002).

The transcripts below are analysed according to three frames (Goffman 1974). The frame indicates 'what was going on' at that particular time in the interaction, that is, which goals, purpose and relationships were foregrounded (Drew and Heritage 1992; Goffman 1974). The three frames are *patient care; education*; and *routine ward practices*. The frames operated alongside each other in the patient room. The interactions are also analysed according to the IRF (initiation, response, follow up) pattern discussed in Chapter 4.

Extract 1: Observing bedside interactions: managing multiple frames in a multilingual patient room

Day 3: Green Hospital: patient room Jing (student) Kim (facilitator) KEY I=initiation R=response				
		FRAME: *Patient care*	**FRAME:** *Education*	**FRAME:** *Routine ward practices*
		Student-patient	Teacher-student	Student-doctor
1	Jing: [*to the patient*] 'temperature'?	Explanation of procedure (& implied seeking of permission)		
2	Jing puts the thermometer in his ear. While she is taking the readings, a doctor comes by and asks Jing if she has the chart for 4/4 [*referring to the patient bed number and the room number*]	Doing the patient care – physical task		Request for information
3	Jing: 'if it's not here it should be at the front desk'			Information provided
4	Kim asks what the blood pressure reading was		Initiation	
5	Jing responds with a number		Response	
6	Kim: 'is it normal'		I	
7	Jing: 'based on the past it's normal'		R	
8	Jing begins to write the result on a piece of paper	Documentation of results		

9	Kim tells her to write straight onto the chart		I	
10	Jing says she didn't know she could write it on the chart and she completes the chart	Documentation of results	R	
11	Kim tells Jing to check if the patient is in pain		I	
12	Jing: 'Pain' [*she says this word in Mandarin*] 'Pain'? [*she repeats the word in English*]	Request for information (pre-closure)	R	
13	The patient indicated by shaking his head that he is not in pain	Information given		

Frames and goals

The complexity of the patient room is illustrated by the three different frames in the interaction: the *patient care frame*; the *education frame*; and *routine ward practices frame*. The goal of the first frame is for Jing to complete the clinical activity. The goal of the second frame seems to be predominantly one of learning and assessment. Kim's prompts from the side in the second frame help Jing complete this activity correctly by documenting the results into the chart instead of on a piece of paper. The goal of the third frame is that of co-workers maintaining the daily routine of the hospital, which includes keeping track of the location of documents. Jing is the only participant in all three frames and has to manage being a student, who responds to her facilitator, in frame one; a nurse, who attends to the physical task at hand, in frame two; and a co-worker, who responds appropriately to the doctor, in frame three.

In the *patient care frame,* Jing is the nurse who carries out the procedure and documents the results. The patient does not address any comments nor make eye contact with Kim the facilitator. What is noticeable here is that Jing can carry out this procedure effectively with minimal talk. As noted earlier, the patient is

Cantonese speaking, and Jing speaks Mandarin but not Cantonese. Nevertheless, she manages to communicate with the patient by using body language and minimal verbal interaction. To ask permission, she holds up the thermometer, says 'temperature', and then shows him the blood pressure cuff. The patient communicates with her by opening his mouth for the thermometer, and lifting his arm for the cuff. To ask if he is in pain, she uses a word in Mandarin, which the patient may or may not understand.

Participant interactions and roles

Both Jing and Kim participate in the *education frame*. Kim interrupts the *patient care frame,* asking Jing questions to check her knowledge and prompt her with corrections. When Kim prompts from her *education frame*, it results in Jing undertaking further action in the *patient care frame*; for example, Jing returns to ask the patient if he is pain when she is prompted to do so by Kim.

The roles in this second frame are those of student and teacher, or expert and novice. However, although Jing is only on her second clinical placement, Kim shows she has confidence in Jing being able to carry out this patient care activity through standing back and prompting from the side, allowing Jing to carry out the interaction herself. Her position away from the bedside makes it clear that Jing is responsible for doing the patient care. The Initiation/ Response pattern beginning in turn 4 suggests that the purpose of this part of the interaction is to check Jing's knowledge. In line 4, Kim does not know the answer to the question she asked Jing, enquiring whether the blood pressure was normal, as she has not checked the blood pressure herself. She is not checking whether Jing's reading was accurate but using this question to lead to the next 'is it normal'. Jing's response in line 7 indicates her understanding that it is not a simple yes or no answer but that 'normal' depends on the patient's previous readings. Kim's instruction, in turn 9, to write the result directly onto the chart, can be also seen as an implicit evaluation of Jing's previous response. When Kim does correct Jing, she does so directly, telling her to write in the chart rather than on a piece of paper, and to ask the patient if he is in pain. Kim is helping Jing to go beyond completing the task and to focus on the

patient, making sure he is comfortable. One of Kim's key messages throughout the clinical placement was to ask patients if they needed anything such as water or their glasses, and whether they were in pain.

In the third frame, *routine ward practices,* Jing is part of a ward team whose members need to cooperate to keep track of patient records. By addressing the question to Jing, rather than the facilitator, the doctor shows he is treating Jing as a member of the team.

The *patient care frame* and the *education frame* in this interaction have minimal talk. Two reasons for this are the language background of the patient and the interactional patterns used by Kim. As the patient speaks no English, Jing uses mainly non- verbal means to communicate with him, with a few words of minimal English and her first language. Likewise, the patient uses non-verbal means to communicate with Jing; for example, opening his mouth indicates that he gives permission for Jing to take his temperature. In terms of communication with the patient, Jing is the expert here. As noted previously, the RN had requested Jing's help in communicating with this patient, earlier that day. In this interaction, English is less important than body language and the few words exchanged in Mandarin, which may have helped develop some affinity with the patient. Jing's communication strategies enable her to successfully manage this patient interaction. The second reason for minimal talk is that the initiations by Kim require only minimal responses by Jing, either in the form of doing something, for example, writing the notes on the chart, or saying something, for example, going back to the patient to ask if he is pain. The facilitator's comments are focused on making sure Jing has the knowledge she needs to interpret if the blood pressure is correct, and that she can complete the task correctly, by recording information in the correct place. Kim's strategy for making sure this occurs is to provide explicit corrections.

Opportunities for learning and assessment

Jing seems to have been able to complete this activity without much prompting. Apart from comments she made about documentation, Kim makes no comments about the actual taking of the blood pressure. Her interaction with Jing focuses more on assessing Jing's competence in the physical skills, rather than Jing learning anything new. Jing seems to be aware that she is being assessed when she demonstrates her knowledge of what 'normal' blood pressure means. Kim's feedback is minimal but ensures the clinical task was completed. From this *observation* in the patient room, Kim can see Jing is interacting appropriately with a patient who could not speak English, is able to get the task done, and is able to interact with a healthcare professional and to respond appropriately to his request.

Observing bedside interactions: interrupting student-patient talk

Setting and access

The setting for this extract is similar to the previous one. Glenda met Soo-jin in the corridor on her daily rounds, discovered that she was about to take vital signs and accompanied her to the patient room. Soo-jin stood next to the patient, who was in bed, to take his blood pressure. The patient is an elderly man who speaks English with a strong European accent. Glenda stood at the end of the bed and slightly off to the side. I stood next to Glenda.

Extract 2: Observing bedside interactions: interrupting student-patient talk (activity one)

Day 8: Red Hospital: patient room Soo-jin (student) Glenda (facilitator) Researcher				
		FRAME *Patient care*	**FRAME** *Education*	**FRAME** *Social interaction*
		Student-patient	Teacher-student	Patient-researcher
1	Soo-jin: can I have your finger [*patient's name*] I'm taking your temperature, is that alright? I'm going to put the cuffs on your arm is that alright?	Request; explanation and permission		

		FRAME *Patient care*	**FRAME** *Education*	**FRAME** *Social interaction*
2	[*The patient lifts up his arm*]			
3	Soo-jin: oh you're helping me now	Comment: phatic		
4	[*Glenda watches her and then says that the cuff needs to be bigger*]		I - correction	
5	Soo-jin: [*laughs*]		R	
6	[*Glenda asks which cuff do you normally use*]		I- elicit information	[*patient begins to talk to researcher- they chat until turn 13 when Soo-jin takes the BP*]
7	[*Soo-jin says that she normally uses this cuff*]		R	
8	[*Glenda says that the patient needs a larger cuff*]		I - correction	
9	[*They go to get a larger cuff*]		R - joint action	
10	[*Glenda tells Soo-jin to swap the cuff*]		I - directive	
11	Soo-jin: can you show me. I never put in here		R &I - request for help	
12	[*Soo-jin needs to remove the cuff from the machine and replace it with the larger cuff. Glenda tries to help Soo-jin but they cannot swap the cuff, as it is incompatible with the machine*]		R - help given	

13	[*Soo-jin takes the blood pressure using the original cuff*]	Carrying out the procedure		
14	Soo-jin: that's it I'm going to take off the cuff thank you thank you so much	Pre-closure, explanation, closure		

Frames and goals

The complexity of the patient room is again illustrated by three frames in operation: a *patient care frame*: an *education frame*; and a *social interaction frame*. The goal of the first frame is for Soo-jin to complete the patient care activity of taking vital signs. The goal of the second frame seems to be to assess whether Soo-jin can correctly take vital signs; and finally, the goal of the third frame seems to be *social interaction*. Soo-jin participates in the first two frames, but not in the third frame of *social interaction*. Glenda only participates in the *education frame*. The patient participates in the *patient care frame* and in the *social interaction frame* with the researcher. It seems the shift from the frame of *patient care* in turn 4 to the *education frame* turns the attention away from the patient and it is at this point that the patient takes the opportunity to speak to the researcher. Initially, he talked about his current health situation but then elaborated by recounting an earlier industrial accident, and his relocation to an 'outback' town, which he credited with helping him recover from his injury due to the hot springs there.

Participant interactions and roles

In the *patient care frame*, Soo-jin includes some of the key components of nurse-patient interactions that she has been taught as part of her degree programme. Students learn that when undertaking a clinical procedure, they need to introduce themselves to the patient; make small talk; explain the procedure; seek consent; give instructions to the patient; and close the interaction (San Miguel et al. 2006). In this extract, Soo-jin does not introduce herself as she already knows the patient; she has been working with him throughout the shift. In turn 1, she gives an explanation that she is going to put an oxygen clip on his finger and seeks consent. In turn 3, she makes a phatic comment that could be classified as small

talk. However, the *patient care frame* is interrupted at that point by Glenda. In turn 4, Glenda corrects Soo-jin's actions by telling her she needs to get a larger blood pressure cuff. It is only in turn 14, that Soo-jin returns to an explanation that she is taking off the cuff and thanks him, indicating that the procedure is finished. What is missing from this frame is small talk between the patient and Soo-jin. The interruption by Glenda shifted the role of Soo-jin as nurse to that of learner. The patient may have noticed this shift and begun to talk to the researcher rather than Soo-jin, who was interacting with her facilitator. Unlike the previous extract, where the patient did not speak English, Soo-jin's patient can speak English. It may have been that had Glenda not interrupted, the patient would have made small talk with Soo-jin rather than with the researcher.

As noted, whilst Soo-jin initially is in charge of the *patient care frame*, and performs as a nurse, the interruption by Glenda switches the focus of the roles to that of learner and teacher. Glenda drives the interaction in this frame with an initiation-response pattern from turn 4-12, which focuses on Glenda making direct corrections, requiring minimal feedback from Soo-jin. Glenda's use of this interactional pattern is an attempt to make sure the patient is comfortable and the blood pressure reading correct, as using a cuff that is too small can result in an incorrect reading. However, due to hospital resources, Glenda's corrections cannot be carried out. In the clinical setting, sometimes nurses 'made do' with what was available and this, at times, conflicted with the practices that students had learned at university. The corrections regarding the size of the cuff in turns 4, 6, and 8 question not only Soo-jin's practice but may also implicitly question the practices of Soo-jin's buddy RN, as Soo-jin has been working with her buddy that day, using the same blood pressure machine located in the patient room for the regular observations she had to undertake. Soo-jin's response to Glenda's explicit correction is to laugh (turn 5). When I observed this, my impression was that she was embarrassed, perhaps because she was being corrected in this direct manner in front of the patient and the researcher. She may also be embarrassed that Glenda is questioning what her buddy RN has been doing with her, although the buddy is not currently present.

Opportunities for learning and assessment

The focal themes in this interaction are safe practice, and the *physical* tasks of clinical work, rather than the *communication* skills needed to establish a therapeutic relationship with a patient. Soo-jin learned here that taking a blood pressure correctly requires using a cuff that is the correct size for the patient. She also learned that correct equipment is not always available in the hospital. Similar to the previous extract, the interactional pattern consisting of direct corrections again offers no opportunities for self-correction by Soo-jin. Glenda's direct corrections, for example, telling Soo-jin she needed a larger cuff rather than asking her, for example, 'what do you notice about the cuff?', suggest that Glenda's focus was to help Soo-jin complete the task in a timely manner. However, Glenda was able to observe that Soo-jin was able to take vital signs; was able to ask for assistance when necessary (turn 11); and was able to explain to patients what she was doing (turns 1 and 14). Soo-jin's body language was also visible to Glenda, which included smiling at the patient and maintaining eye contact; as was Soo-jin's attempt to establish rapport (turn 3). What Glenda could not assess was Soo-jin's ability to understand the patient, nor her ability to do any kind of small talk as the *education frame* had interrupted the *patient care frame*. In Glenda's follow up in the corridor after this interaction, the physical task of the clinical skill was again the focus of discussion, rather than communication with the patient.

In these two examples of the facilitator *observing bedside interactions*, the aim is to get the patient activity done in a timely way and safe manner, and to ensure patient comfort. Both students complete the activity, with prompting from the side for Jing, and a direct correction for Soo-jin. It is clear from these extracts that, although the students are participating in a patient care activity, in that they undertake the skill, the facilitator has the right to interrupt that activity and correct the student in front of the patient. The focus on making sure the procedure is correct may have drawn attention away from a focus on building a relationship with patients. Furthermore, as can be seen in Extract 2, with Soo-jin, the patient seems to have shifted his attention away from the student when the frame shifted to one of *education* rather than one of *patient care.* This happened throughout my fieldwork when patients took the opportunity to 'have a chat' with the researcher.

Working alongside (activity two): when facilitators talk for students

Working alongside describes activities where the clinical facilitator entered the patient room and either joined in with what the students were doing or suggested what the students should be doing. These activities involved facilitator, student and patient. Sometimes the RN was also in the room but tended to be working with other patients. The activities were usually unscheduled in that Mel and Glenda, and Kim in the first week, dropped into patient rooms as part of their daily rounds; if students were completing clinical tasks, facilitators sometimes began to *work alongside*. In the second week, Kim, Green Hospital, spent scheduled time with each student in their patient room, *observing* and *working alongside* them for approximately an hour with whatever tasks they were undertaking. Although the visit was planned and in some cases scheduled for time, the focal themes and activities undertaken were dependent on what was happening in the patient room at that time. The *working alongside* activities typically focused on tasks such as bed making; tidying the bedside area; checking equipment; mobilising patients; giving breakfast; showering patients and taking an ECG. The following extract shows how the facilitator at times intervenes and does things for the student (Poehner & Lantolf 2005). The extract also shows how the facilitator is the one who talks most with patients.

As was the case in *observing bedside interactions* activities, the focus in *working alongside* activities, tended to be on students completing a physical skill rather than communicating with patients. The facilitator's explicit comments on, or demonstrations of, the physical aspects of clinical skills, enabled students to complete activities that they could not do without assistance. In contrast, while facilitators' interactions with patients frequently represented successful models of establishing therapeutic relations with patients through small talk, communication was not commented on explicitly by either facilitators or students.

Working alongside: facilitator talk - student silence

The next extract also illustrates the multiple frames at play in the patient room. However, this extract differs from the previous ones in that both the student and

her facilitator participate in the *patient care frame*. In this particular extract, the facilitator talks and the student is mostly silent.

Setting and access

This activity came about due to an unscheduled meeting in the corridor, where Glenda (Red Hospital) asked Hua what she was doing, discovered that she was about to take a patient's vital signs, and accompanied her to the bedside. The patient was in a four-bed room, and Glenda stood at the end of the bed and slightly to the side, initially observing, while Hua took the patient's vital signs. I stood behind Glenda. The patient was an elderly man from rural New South Wales who spoke English as his first language. The RN was not in the room at the beginning of this activity. Hua seemed to have some knowledge about this patient and told Glenda before walking up to the patient that he had been unwell that morning and they were not sure what the problem was.

Extract 3: Working alongside: facilitator talk - student silence

Day 7:
Glenda (Facilitator)
Hua (Student)
In the *patient care frame*, the lines in bold are those spoken by the student. The lines not in bold are spoken by the facilitator.

		Frame *Patient care*	**Frame** *Education*	**Frame** *Social interaction*
		Student-patient; facilitator-patient	Student - facilitator	Patient - researcher
1	[*Hua takes the patient's vital signs. She is quiet and does not talk a lot*]	Doing task		
2	[*While Glenda is observing Hua, the patient turns to me and begins talking about where he is from and what he does*]			Small talk – with researcher

3	[*Glenda asks pt. if he would like to put his teeth in*]	Talk not directly relevant to BP task but noticing that he has not teeth		
4	[*He says he doesn't bother with dentures because the sheep kick them out*] * the reference to sheep is explained below	Small talk, with a dual purpose of gathering information about the patient		
5	[*Glenda asks him what he eats and he tells her the kind of food he eats*]			
6	[*Pt. says to Glenda*] what do you reckon, is she any good [*referring to Hua*]	Small talk - joking		
7	Glenda: she's good	Responding to joke		
8	Glenda: do you mind if Hua takes the other tape off [*from his wrist or hand*]	Asking permission for Hua		
9	Pt*:* it's just a piece of sticky tape	Response		
10	[*Glenda is showing and explaining to Hua how to take the tape off*]		Explanation as to how to remove tape	
11	Pt*:* she'll take this idea and sell it back to the Chinese [*said in a friendly, joking tone*]	Small talk - joke about student		
12	Hua*:* **I'm not from China** [*said quietly and clearly in a factual tone*]	**Student's response**		

13	[*Glenda asks the patient if he heard what Hua said*]	Response - advocating for student		
14	[*the patient says he heard her*]	Acknowledgement		
15	Glenda to pt*:* I just want to have a conversation with Hua about your table	Explanations to patient – explicit switch of activity		
16	Glenda to Hua: so one of the things to do when you're with your patient is just keep the area clean as well -you can get one of those toughies, those wipes to clean his table [*Glenda gives Hua a wipe*]		I - directive	
17	[*Hua wipes the table*]		R - action	

Frames and goals

There are again three frames in this extract: *patient care*; *education*; and *social interaction*. The *patient care frame* in this extract differs from the previous two extracts in that, here, both facilitator and student are participants. However, Hua does most of the physical activity and Glenda does most of the talking. The goal of this frame is to take care of the patient beyond the task of completing vital signs. Glenda's participation in the frame helps achieve this. The goal of the second frame, the *education frame*, seems to be to show Hua how to notice things about the patient and his surroundings beyond the clinical skill she is undertaking. The goal of the third frame seems to be *social interaction*.

Participant interactions and roles

At the beginning of this interaction, while Hua is concentrating on taking the blood pressure, Glenda has an open writing pad in her hand, and writes comments as she

observes Hua. The *education frame* and *patient care frame* operate simultaneously here. At the same time, the patient turns to me (turn 2) and begins to chat. He seems to be aware that there is an *education frame* going on, that the focus in turn 1 is on the facilitator observing Hua, and he takes the opportunity to chat about where he is from and how long he has been in hospital.

However, Glenda notices when the patient is talking that he is not wearing teeth. She picks up on this, and in a shift back to the *patient care frame*, asks him if he wants to put them in (turn 3). When he replied that he does not bother with them, Glenda follows up by asking how he eats without teeth and what kind of things he eats (turn 5). For the patient, this seems to be a kind of social chat as he crosses frames from chatting with the researcher to responding to the facilitator's questions. He does not respond as if this is a series of questions about his health, but rather, as if he is enjoying a social talk. He continues to talk about his farm and explains that if he wore his teeth the sheep kick them out so he does not bother wearing them. His comment about Hua, in turn 6, 'what do you reckon, is she any good', was said in a joking manner and suggests that Glenda and the patient had established some form of rapport, as joking and teasing are often used as solidarity markers (Holmes 2003). However, for Glenda, as well as building rapport, this kind of talk also serves to gather important information about the patient. As noted by Defibaugh (2014), it is sometimes difficult to determine whether small talk is being used to gain health information or to create solidarity and lessen distance. It seems here it is serving both purposes of getting things done and building rapport.

In contrast to the talk between Glenda and the patient, Hua completes taking the vital signs with very little communication. She does not introduce herself as she had already worked with the patient, she does not make any small talk, nor give instructions, nor ask permission. Permission for blood pressure to be taken was given non-verbally by the patient, as he lifted his arm for Hua to put on the cuff. Glenda talks more than Hua: she makes small talk (turns 3-7), asks the patient's permission for Hua to remove the tape (turn 8) and explains to the patient when she is switching frames from a *patient care frame* to an *education frame*, telling him she is going to explain to Hua about his bedside table (turn 15).

The only comment Hua makes is a response to the patient in reply to his attempt at a joke in turn 12. This can be seen as a potentially troubled moment in the dialogue where what the patient seems to think was a tease or a joke is taken seriously by Hua. The patient attempts to continue his joking relationship with the facilitator by making a joke about Hua. For the patient, the tape on his hand was of no consequence, but Glenda explained in detail and demonstrated to Hua how to remove the tape (turn 10) without hurting the patient's skin. His comment in turn 11 suggests that he sees Hua as Chinese person who will return to China with something she has gained in Australia and will profit from it. Whilst the patient may have intended this as friendly banter, a solidarity marker (Holmes 2003), Hua seems to interpret this as a serious comment and responds that she is not from China. Glenda seems to support Hua by checking the patient had heard Hua's comment. The troublesome moment is smoothed over as Glenda then switches frames (turn 15), turning away from the patient and focusing attention on teaching Hua.

While part of the goal of the *education frame* may be to assess that Hua can take vital signs, Glenda focuses on extending Hua's professional competency beyond the clinical skill to notice other things about the patient and the space around the bed. She directs Hua to tidy the bedside table and gives her instructions as to how to remove the tape that was on the patient's hand. Feedback is again minimal and aimed at giving clear instructions for completing tasks that Glenda thinks are important: cleaning the table and removing the tape. Unlike the direct corrections in the previous extract, Glenda modalises (softens) her instruction here (turn 16), perhaps as it is not a direct correction affecting the clinical skill that is the main focus of the interaction (taking vital signs), but something additional for Hua to focus on. It also mitigates the power imbalance between Glenda and Hua; and it may be that Glenda is aligning herself with Hua after the patient's attempt at a joke about Hua in turn 11.

There are several reasons why Hua may not have talked much during this activity. Firstly, Glenda's presence and her participation in the *patient care frame* meant that Hua did not need to talk, as Glenda did the talking for her in turns 3, 5, 8 and

15. The *education frame* positions Hua as a student and the patient is aware of this as illustrated by his comment 'is she any good'. Apart from the operation of multiple frames, there were additional barriers that may have contributed to Hua talking minimally. The patient positions Hua as a 'Chinese student' (Hua was actually from Taiwan) and may be assuming that she does not speak much English, or he may have made this judgement based on previous interactions with Hua that day. This positioning of Hua as a 'non English speaking' student may have led the patient to talk to the facilitator and the researcher rather than to Hua. The strong Australian accent with which the man spoke, and the lack of teeth would have made it challenging for Hua to understand. When I asked Hua and Ravindra later about the patient's farm and the sheep kicking his teeth, it became clear that they had not understood this part of the conversation.

Hua's own lack of confidence in her English language performance may also have contributed to her minimal talk here. Hua commented in an interview that she was nervous to speak when the facilitator and researcher were present in case she made mistakes, as she did not think her English was as good as the other students.

> I am not worried about the skills that we are performing … but I am more worried about … because compared to the other two students … their English level much higher than me so they can just talk to patients, talk to whatever they want to talk and for me … if you two are not here then I will be more relaxed um and I can talk whatever I want to talk but if she is here I will feel nervous and I it kind of you know (1) um yes too nervous to talk properly.

Opportunities for learning and assessment

Although in this interaction Hua has the opportunity to learn about gathering health information while making small talk with a patient, it is not clear whether Hua was aware of what Glenda was doing, as Glenda implicitly models this talk but does not draw Hua's attention explicitly to it. There is also a missed opportunity for Hua to talk with Glenda about the role of teasing in social interaction and possible cultural patterns in the use of humour. Glenda could at a later point have

asked Hua how she felt about the patient's comments, and how she might respond in future, but this did not occur. The focus of learning in this interaction was to go beyond the clinical skill Hua is completing and pay attention to what is around the bedside and to patient comfort. With Glenda's support, Hua learns to maintain hygiene on the bedside table and to remove tape from the patient's skin whilst ensuring his skin is not damaged.

During this interaction, Glenda can see that Hua is able to take a patient's vital signs, can follow Glenda's instructions to clear the bedside table and remove the tape, and understands at least some of what the patient says, as indicated by her comment that she is not from China.

Managing learning in complex settings

The patient room provides opportunities for facilitators to observe EAL students as they participate in patient care activities, and to prompt and correct their clinical skills to ensure students learn correct nursing procedures. The clinical skills that students perform in the examples in this chapter are ones they performed regularly throughout the placement under the supervision of their buddy RN. Performing them in front of the facilitator introduces a more explicit *education frame*. The patient room also provides opportunities for students to participate collaboratively with the facilitator in skills beyond their current capabilities, for example, removing tape or a dressing; noticing things beyond the immediate clinical skill to attend to holistic patient care; and to complete skills that they cannot perform alone, for example, taking an ECG. In extracts 1 and 3, the facilitators noted what students could complete alone, the taking of the blood pressure, then worked beyond that capability to help them attend to other patient needs, that is, checking patient comfort and hygiene. The facilitators were working in the students' ZPD to scaffold nursing actions so that students could undertake increasingly complex activities. Finally, the patient room is a space where facilitators can model small talk with patients and observe how students interact with patients in a hands-on way (Iedema et al. 2010).

The patient room, however, can also constrain learning opportunities, and in particular opportunities for second language socialisation. The complexity of the patient room in terms of frames, participants and roles, as well as the linguistic diversity of patients, can result in minimal student talk, which provides few opportunities for facilitators to observe and assess students' verbal communication with patients. The patient room may also present limited opportunities for facilitators to assess EAL students' ability to make social talk with patients. As noted earlier, some students, like Hua, were nervous when the facilitator and researcher were present, and this contributed to her lack of talk with the patient. EAL students may be more likely to communicate with patients when there is no audience watching them.

The findings in this chapter add to the limited research that investigates bedside encounters where students, patients and supervisors are present (Ajjawi, Rees & Monrouxe 2015; Rizan et al. 2014). That research considered the complexity of such encounters due to the coexistence of activities that focus on education and patient care. It focused on both the learning opportunities in these encounters (Ajjawi, Rees & Monrouxe 2015) and the effectiveness of supervisor feedback in the encounters in developing student learning (Rizan et al. 2014). The findings in this chapter build on earlier research in that they demonstrate the particular challenges for facilitators and students who work in hospital wards rather than GP consulting rooms. My study also pays attention to previously neglected aspects of bedside encounters, that is, the language performance and capacity of students from linguistically diverse backgrounds.

The findings in this chapter also extend Spafford, Schryer and Creutz's (2009) study that investigated the effects of competing patient care and student education activities. Their study focused on the effects of these competing activities on students' opportunities to learn the delivery of bad news. Similar to my findings, Spafford, Schryer and Creutz (2009) found that supervisors can limit the opportunities for students to learn communication. However, their study was based on interviews rather than observation, and, as with Ajjawi, Rees and Monrouxe (2015) and Rizan et al. (2014), the focus was not EAL students. In terms

of investigating opportunities for language socialisation for EAL students in the clinical workplace, the findings in this chapter are unique and add to the important work by Duff, Wong and Early (2002), which investigated opportunities for language socialisation in clinical placements, as discussed in Chapter 3.

Managing and producing frames in the patient room

Previous studies have shown that students and supervisors consider learning opportunities for EAL students during clinical placement may be limited due to students' poor language skills (Mikkonen et al. 2016b), attitude to learning, and a lack of confidence (Brown 2005; Ladyshewsky 1996). In the extracts in this chapter, students' lack of confidence in English language did appear to contribute to minimal talk on their part. However, the extracts also suggest that it is not just individual confidence, attitudes to learning and language proficiency that play a part in providing access to and engagement in opportunities for learning. In the patient room, there are multiple activities, frames, participant roles and relationships that impact on interactional patterns, which contribute to opportunities to talk. The presence of multiple frames during activities means students need to attend to patient needs, the physical task at hand, the instructions and corrections of their facilitator, and sometimes requests or directions from colleagues. Managing multiple frames is a cognitively demanding burden (Tannen & Wallet 1987) and students may need to find strategies to manage this burden. As well as managing multiple frames, students have to manage multiple activities within frames. In the *patient care frame*, for example, students are often carrying out a physical task that may require concentration, such as, taking a blood pressure. As these skills are relatively new to students, many students may still need to pay conscious attention to them, preventing them from simultaneously talking with others (Billett 2015). As Angie commented in her interview, it was difficult to do and to talk at the same time.

In managing multiple frames, students may prioritise the *education frame*, as they may see the goal of this frame as assessment, and adjust their behaviour accordingly to perform to supervisor expectations rather than patient needs (Ajjawi, Rees & Monrouxe 2015; Spafford, Schryer & Creutz 2009). In previous

studies, students inappropriately adopted medical jargon when talking to the patient (Ajjawi, Rees & Monrouxe 2015), and altered the delivery of bad news to meet the supervisor's expectations rather than the patients (Spafford, Schryer & Creutz 2009). In my study, some EAL students may have remained silent or minimised talk because they were concerned that the facilitator was assessing their communication and they were not confident in speaking English, which is how Hua explained her behaviour in an interview.

However, these extracts show that it is not just the students' perceptions of their language level, nor a prioritising of the *education frame* that results in a lack of talk. It is also a product of how students, facilitators and patients behave to maintain the frames, and the different behaviours required in each frame. Tannen and Wallet (1987) illustrated in their study, which analysed an encounter between a mother, her child and a consultant, that frames are produced interactively and all participants contributed to their maintenance. Some of the frames they identified in their research were: an examination frame when the doctor was examining the child; within this frame, an overlapping education frame when the doctor turned to a video camera and reported findings for an education session; and a consultation frame with the mother. When the doctor reported to the video in the education frame, the mother remained silent, even though she frequently interrupted the examination frame, and thus her silence helped maintain the education frame at that point. At the same time as this interactive production, the frames also conflicted. For example, questions asked by the mother during the examination of the child interrupted the examination frame. As a result, the doctor had to take time to respond to the questions, and the child became restless and difficult for the doctor to manage.

Similarly, in the findings presented here, the *patient care frame* and the *education frames* are produced interactively by participants and may also coincide and conflict at different moments. The *education frame* can interrupt the *patient care frame*, shifting the focus away from the patient and on to the skill or equipment. This switch to an *education frame* can affect both the way the student interacts with the patient and the way the patient responds to the student. As illustrated in

extract 2, students' opportunities to make small talk can be interrupted by the facilitator explicitly correcting the student. These corrections interrupt the student-patient communication and shift the focus of the students' role from that of nurse to student. This results in the student turning away from the patient–nurse discourse to a student-teacher discourse. At the same time, patients were seen to help maintain the *education frame* by opting to turn to the researcher for a social chat rather than chatting with the student.

Limited opportunities for student-patient talk

Participation by facilitators in the *patient care frame* at the bedside may reduce opportunities for students to talk. The more facilitators participate, the more they seem to talk **with** patients, and **for** students. Spafford, Schryer and Creutz (2009) found similarly that, although supervisors knew that students needed to develop their communication skills in delivering bad news to patients, the supervisors often delivered the news. The participation in both *patient care* and *education frames* changes, based on moment to moment decisions made by supervisors depending on the patient's problems, a concern for patient well-being and what the supervisor assessed the student's level of capability to be (Rizan et al. 2014; Spafford, Schryer & Creutz 2009). In the extracts I have discussed here, it can be seen that facilitators particularly tend to do the small talk when they participate in *patient care frames*. Whilst this small talk by the facilitator potentially offers opportunities for EAL students to be socialised into the language of small talk through role modelling, the lack of explicit attention paid to it means it is unclear whether students are aware how and why the facilitator is communicating with patients.

One of the reasons that facilitators do the small talk may be to minimise communication, in order to make physical tasks manageable for EAL students. Their focus on clinical tasks, and safe practice, rather than building rapport through small talk, suggests that facilitators prioritise the physical skill, rather than communication. As expert clinicians, facilitators were aware of the importance of small talk with patients, as illustrated by a comment Kim's made to me:

> I think patients like it when nurses have a bit of a talk to them and don't just do the work, I think they like they sort of bond to you more when you talk about their family or their work.

However, similar to findings in Spafford, Schryer and Creutz (2009), the facilitators in my study seemed to hold the view that students will learn to communicate through legitimate peripheral participation over time (Lave & Wenger 1991), rather than through any explicit instruction. Both Kim and Glenda said that learning to talk to patients 'takes time'. The lack of any explicit comments on small talk, either in the patient room, or in the later feedback sessions, may be explained by Lu and Malthus's (2012) proposal that many supervisors, who are often fluent speakers of English, may not be aware of the social role of language use. Furthermore, they may not consider it their role to 'encourage students to explicitly attend to the socio-cultural "work'' that is happening' (Lu and Malthus 2012, p. 10) in clinical interactions. However, as argued by Spafford, Schryer and Creutz (2009, p. 247), 'effective learning depends on more than a passive progression through the levels of legitimate participation', and explicit scaffolding of communication may help students acquire skills more quickly. The lack of opportunities to do small talk, as well as the lack of explicit comments by facilitators when they model communication with patients, may be missed opportunities for EAL students in particular, for whom the socio-cultural norms of small talk may be unfamiliar (Lu & Malthus 2012). As Lu and Malthus (2012) argue, supervisors have a role in making the language of the nursing profession explicit to EAL students in order to help them develop communication skills, and one of the important skills is to use small talk to build a therapeutic relationship.

Despite the lack of explicit attention to communication skills in the patient room, facilitators did notice how students communicated with patients. Sometimes these comments tended to be directed to me rather than to students, and were often made after facilitators had viewed students from a distance by standing in the corridor and looking into a patient room. Glenda describes her strategy for observing students without them knowing:

> What I really like is actually doing the morning shift because quite often what I will do is while we're in a four bed room and they're helping someone in the shower or this that or the other, I'll go and make beds because I can watch and hear what they're and how they're interacting with their patients … and that gives a really good sort of where they're at.

The comments tended to be brief and general and inferred small talk rather than mentioning it explicitly. On the fifth day, Kim told me that that Maymei was speaking 'nicely' to her patients and is 'talking more than nursing'; on the sixth day, she remarked to Angie that her communication is 'good' as 'she is talking to her patient and the patient is talking to [Angie]'. These findings are similar to previous findings that health professionals tend to focus on health outcomes rather than communication skills when assessing students' performance (Elder et al. 2012; Woodward-Kron et al. 2012).

Multilingual patients and students

Finally, the linguistic diversity of patients also means that EAL students may not have opportunities to be socialised into small talk in English, either because patients do not speak English or because the kind of English that patients speak may be difficult for students to understand. It is not within the scope of this study to discuss the benefits and challenges of students speaking their first language during their clinical placement, although for some students that proved to be an important part of their clinical experience. What was noticeable about the wards I observed was the number of patients for whom English was an additional language, which meant that at times communication in English was limited. As found by Duff, Wong and Early (2002), students here needed to use other means of communication. Extract 1, in this chapter, illustrates how students can work with patients who do not speak English by adapting how they communicate. In a study on how experienced nurses describe procedures, Major and Homes (2008) found that nurses adjust the way they communicate according to the situation. For example, one patient did not like to talk about health but preferred to talk about her family, and so the nurse spent minimal time talking about the procedure but talked instead about the patient's family. In my study, both patients and students

seem to have adjusted their behaviour and talk in response to each other's language background. Although Major and Holmes (2008) found that a core component of the nurse-patient interaction was a description of the procedure, in two of the examples presented here this was achieved though non-verbal communication and minimal talk. In Jing's case (Extract 1), the patient lifted his arm and Jing used an abbreviated description for the next step of the procedure, saying 'temperature' and showing the thermometer. In this way, Jing can be seen to be successfully adapting her interaction to suit the patient who did not speak English. In Extract 3, Hua's patient did speak English but he also lifted his arm without Hua providing any instructions or explanation. Although it was not necessary for Hua to describe what she was doing, her reliance on non-verbal communication and her lack of small talk may have contributed to the patient talking to the researcher and facilitator rather than Hua. In this example, it may also be the case that the patient perceives Hua's language background as a potential barrier to communication.

Limited opportunities for talk about clinical skills

Apart from limiting opportunities for small talk, the competing *patient care* and *education frames* may limit talk about the clinical skill that students are doing. As the goal of the *patient care frame* is to complete the task in a timely manner, facilitators tend to give minimal feedback, in order to keep interactions short. However, as Rizan et al. (2014) argue, if feedback is too direct with immediate correction of errors, students may not be participating in the learning and may lack opportunities to self-correct. In this kind of feedback, supervisors provide a solution rather than a scaffold towards an answer. The extracts in my study show that facilitators in this study mainly offered direct feedback in the form of explicit corrections or directions for further action. In Rizan et al.'s (2014, p. 909) study rather than using explicit correction, some supervisors used 'embedded feedback', that is, strategies that helped students self-correct errors by guiding them to the correct answer. Indirect corrections have been credited with helping to preserve students' identities as medical practitioners in front of the patients (Rizan et al. 2014) or in front of their supervisors (Erickson 1999) by allowing students to self-

correct where possible and by providing face saving techniques when the supervisor needs to correct an error directly.

In my study, facilitators did not usually give indirect feedback at the bedside. Unlike the more advanced students described in previous studies, the novice status, and language background of students in my study may have influenced facilitators to choose direct correction for two reasons: firstly, in order to manage the interactions in a timely manner; and secondly, to preserve the professional identity of the student. As one facilitator said, she could not ask students too much in front of the patient, as patients need to have a level of confidence in students, in order to allow them to undertake any clinical procedures. Above all, direct feedback seems to be about ensuring the well-being of a patient, ensuring that these novices can, in the early stages of their career, participate in patient care in a safe manner. In that sense while the facilitator may use embedded feedback in other spaces (as illustrated by Glenda, the facilitator in Red Hospital, in the next chapter), in the patient room they may use direct feedback in an attempt to balance the *education* and *patient care frames*.

Conclusion

This chapter demonstrates the complexity of the patient room for EAL students and facilitators due to the multiple frames at play and the multilingual nature of Australian hospitals. The patient room is at the heart of clinical placement, providing access to opportunities for learning and assessing hands-on clinical skills, which are essential in ensuring students can practise safely. In Ajjawi, Rees and Monrouxe (2015), GPs seemed to mainly lead the interactions and activities in the *patient care frames,* with students participating only when invited and sometimes not at all. However, in my study, the patient room offered important opportunities where students could lead the *patient care frame*, and thus legitimately participate in core nursing activities. In this sense, these interactions are akin to what Spouse (1996) termed 'coaching' in that the students are the key actors and the facilitators guide from the side. This coaching, however, was limited to physical skills. These activities also offered facilitators opportunities to observe

and assess students' ability to interact with patients, to communicate with patients non-verbally, and to follow instructions and corrections.

However, given the multiple frames at play and the focus on completing physical skills in a safe and timely manner, the patient room as it was used in this study did not offer many opportunities for second language socialisation, and in particular for opportunities to develop small talk. It also offered few opportunities for facilitators to observe and assess students' ability to communicate with patients in terms of building rapport. Whilst there were examples of students being able to observe facilitators making small talk with patients, it is not clear to what extent this helped EAL students to be socialised in the socio-cultural norms of making small talk as it was rarely, if ever, explicitly commented on by facilitators. The metaphor of participation without explicit scaffolding (Spafford, Schryer & Creutz 2009) seems to predominate in describing how students learn communication skills with patients.

EAL students, in particular, may benefit from explicit attention being paid to building rapport with patients through small talk. Facilitators could make this process more visible when opportunities arise by firstly, becoming aware of when and how they participate in the *patient care frame*, and then analysing elsewhere the topics and purpose of the talk that occurred.

The patient room also did not offer opportunities for facilitators to find out what students had understood about the physical skills they were undertaking, that is, the clinical knowledge underlying the physical tasks. The emphasis on the *patient care frame* resulted in facilitators mostly telling students what to do to complete tasks, rather than providing opportunities for students to self-correct. In terms of creating opportunities for students to talk about the skills they have been undertaking and to talk about their patients, it seems what is important is that facilitators create an educational space elsewhere to analyse the interactions in the patient rooms. Glenda was the only facilitator who regularly did this. This is the focus of the next chapter.

Chapter 8 - Corridor: thinking like a nurse

Corridor interactions between supervisors and students have been referred to as ad hoc teaching (Pearce 2003), corridor supervision, supervision on the run (Morrison et al. 2014) and teaching on the job (Eggins 2016), and are considered an important part of clinical supervision. However, it has also been argued that corridor teaching focuses more on gathering information about a patient, leading to a diagnosis, rather than ascertaining what the student knows (Molodysky 2007), and that it may result in students being given the answer rather than learning (Pearce 2003). A recent study by Eggins (2016), drawing on audio recorded teaching interactions between senior and junior doctors, shows that corridor interactions can provide learning opportunities for students when supervisors use teaching strategies that are described as demonstration, declaration and elicitation. Demonstration refers to interactions where doctors predominantly modelled clinical activities, for example, reaching a diagnosis, by thinking aloud. Eggins (2016) uses this term to refer to verbal demonstration, not physical demonstration. In declarative teaching interactions, senior doctors used opportune moments to point out significant factors and provide correct information. In elicitation style interactions, doctors scaffolded junior doctor's thinking by prompting for missing information. The context of each incident and the senior doctor's judgement of the junior doctor's competence influenced the type of teaching interaction that occurred: for example, an elicitation style interaction relied on a higher level of shared knowledge between the senior and junior doctor than did the other two types of interaction.

Eggins (2016, p. 167) argues that these three types of teaching interactions help junior doctors become part of the medical community of practice by helping them to 'notice, classify, decide, talk and manage like a doctor'. Eggins' (2016) study extends the existing healthcare literature that draws on situated learning and community of practice theories (Erickson 1999; Le Maistre, Boudreau & Paré 2006; Skøien, Vågstøl, Raaheim 2009; Spouse 1998a) by illustrating the role that language plays in apprenticing students into the discourse of the community (Lave and Wenger 1991).

The existing literature described above provides important insights into teaching interactions in clinical environments, and in particular in the corridor. However, it differs in several ways from my study. Firstly, that research focused on junior doctors who were more advanced in their degree than are the first year nursing students in my research. Secondly, there was no focus on students for whom English is an additional language. Finally, the teaching encounters occurred as part of the on-going work of the ward or GP clinic. Many of the teaching interactions that Eggins (2016, p. 168) observed took place in the corridor as '[doctors] jostle their way along busy ward corridors en route to examining the next patient', where noise and the busy atmosphere impacted on the kind of interactions that could occur. In the GP registrar studies (Morrison et al. 2014; Pearce 2003), most interactions were initiated by the students who sought their supervisors' advice about the patients they were examining. Corridor interactions between GPs and students, and some of those described by Eggins (2016), are referred to as ad hoc because they were usually unplanned. In my study, the role of the facilitator differs from those of the supervisors in the above literature. As educators employed by the university and without a patient care load, there were opportunities for facilitators to use the corridor as a place to step aside from the daily ward routine, to stop and talk about interactions that had occurred in the patient room rather than talking en route, as they rushed to their next patient. In this sense, the corridor was used as a retreat from the, at times, competing frame of *patient care*.

This chapter discusses how Glenda used the corridor as a place for *follow up talk about bedside interactions*. It considers the content of that talk, the participant roles of facilitator and students, and the teaching strategies Glenda used with students to reflect on nurse-patient interactions she had observed.

Activity: Follow up talk about bedside interactions

One of the main activities in the corridor that Glenda engaged in with students was *follow up talk about bedside interactions*. Glenda was the only facilitator who regularly engaged in this activity. After *observing* or *working alongside* students in the patient room, or after observing other healthcare professionals with students,

Glenda directed students to the corridor, in order to talk about the activities observed. This chapter focuses on the feedback sessions that followed *observations* of the students' interactions with patients.

As noted in the previous chapter, (Table 17), on five days, Glenda observed students in the patient room and then moved to the corridor to discuss the observed interaction. Glenda initiated this activity and all EAL students had opportunities to talk with Glenda. Although Kim, Green Hospital, regularly observed students in patient rooms, she did not initiate follow up sessions elsewhere. In Blue Hospital, Mel rarely observed students in patient rooms; she spent more time working alongside them. The only follow up session occurred when one student had completed a task that was beyond her scope of practice, and Mel spent time correcting and reprimanding her. The frequency of *follow up talk on bedside interactions* is summarised in Table 16, below.

Table 16: Frequency of follow up talk on bedside interactions

Hospital	**Number of *observing bedside interaction* activities**	**Number of days that activities occurred**	**Number of *follow up talk on bedside interaction* sessions**
RED (Glenda)	14	5	14
GREEN (Kim)	13	7	0
BLUE (Mel)	2	2	1

The main focal theme of the *follow up* sessions was safe practice, which included hygiene practices; following correct procedures when undertaking clinical tasks; using the correct equipment; and student roles and responsibilities. Glenda also focused on the clinical decision making process followed by nurses, drawing on a framework with which students were familiar from their university studies, that is, Tanner's (2006) framework for making a clinical judgement about patient care. The model is a cyclical process with four stages:

i) noticing, which involves assessing the situation, using objective and subjective data, for example blood pressure results and patient reports of pain

ii) interpreting, which means making sense of the data
iii) responding by planning appropriate care
iv) reflecting, which includes both reflection-in-action and reflection-on-action.

Reflection-in-action involves monitoring the effectiveness of the care given to a patient. Reflection-on-action refers to the nurse's reflection on the whole situation after the event. Glenda used this framework in helping students to notice things about patients, interpret what they had noticed, and decide what action to take next. Students' actions included reporting what they had noticed to the RN; frequently monitoring vital signs; and using nursing terminology to document what they had noticed.

The following two extracts illustrate how Glenda helps guide students through the nursing process so that they can begin to develop the skills required to make decisions about patient care. The first extract (no. 4) demonstrates how Glenda helps guide a student to complete a patient care activity. In this extract, Glenda does most of the talking. The second extract (no. 5) also focuses on Glenda helping a student to make decisions about patient care. In the second extract, the student participates to a much greater extent than the student in the first extract. The two extracts illustrate how Glenda adjusts her pedagogic approach according to her judgement on what the students know or do not know and can or cannot do without help.

Follow up talk about bedside interactions: guiding students to interpret and respond to respiratory abnormalities

Setting and Access

On the second day of the clinical placement, Glenda had observed Ryoko taking a patient's respiratory rate by visually counting the number of breaths the patient took per minute. As the rate had been outside of the normal range, Glenda had suggested to Ryoko that she should return ten minutes later to check again with a stethoscope. During the next ten minutes, as Ryoko washed her hands at a sink in

the corridor, Glenda and Ryoko talked about Ryoko's home country, Japan, and her previous employment. Glenda also chatted to Ryoko about her own experience of snowboarding in Japan. Glenda concluded this conversation by suggesting that they return to take the patient's respiratory rate. After checking the respiratory rate, Glenda directed Ryoko to move to the corridor. The position where Ryoko and Glenda stood is illustrated in Figure 7. They were in close proximity to a door that lead to the patient room, where Glenda had just observed Ryoko. This corridor was a transit route between the main door of the ward and the patient room (and beyond it to the nurses' desk, and other patient rooms).

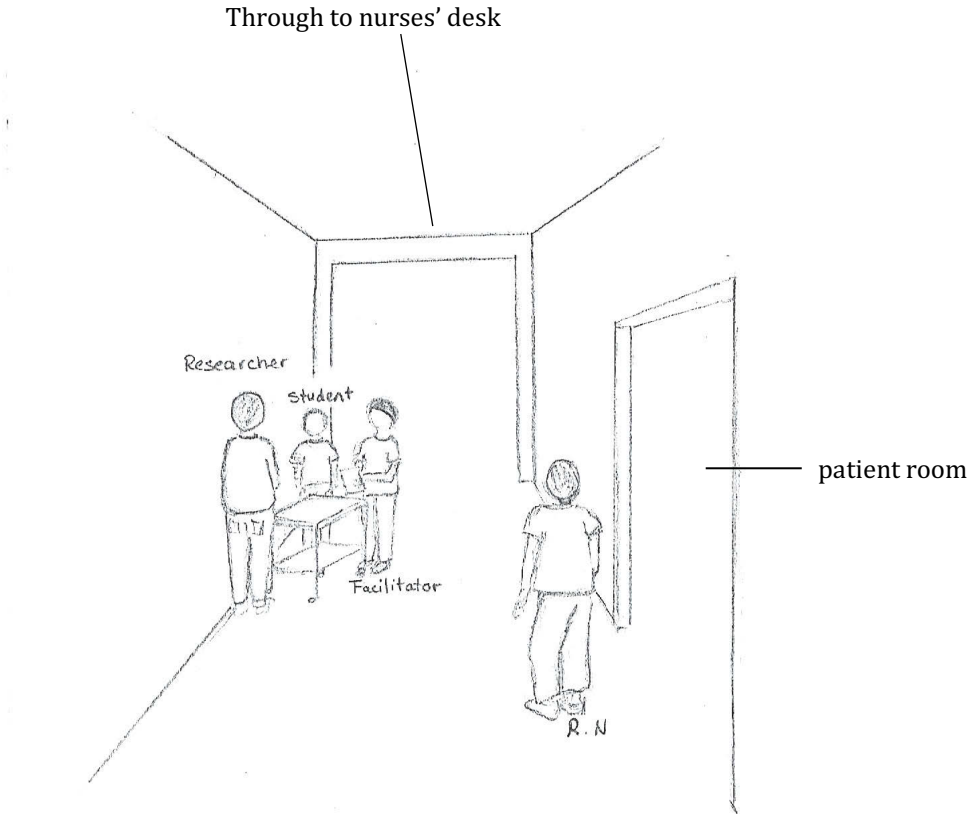


Figure 7: Feedback in the corridor

As Glenda and Ryoko talked, other healthcare staff, carrying charts and pushing trolleys, walked back and forth, and family members were arriving. The level of background noise varied throughout the interaction. At times, there was a constant low murmur of voices, and sometimes louder voices as people passed. Patient bells constantly buzzed, and there was some loud rattling of trolleys as other workers moved along the corridor. Although the conversation was in a public space, Glenda

created a sense of privacy by standing around a hospital trolley, close to Ryoko so they did not have to speak very loudly. There was a sense that Glenda and Ryoko were standing aside from the busy atmosphere of the corridor, and able to use the space to stand and take stock of what had just happened in the patient room. In terms of maintaining patient confidentiality, it is very unlikely patients would have heard any of the discussion, as we were approximately three or four metres away from the patients, and on the opposite side of the corridor from the doorway to their room. Given the ambient noise, it would also have been difficult for passers-by to pick up what was being said. The interaction lasted approximately ten minutes.

The extract below is from the corridor interaction between Glenda and Ryoko. For purposes of analysis the extract has been divided into five stages. Each stage had a specific goal, and Glenda used different pedagogic strategies within each stage to achieve those goals. The interaction is analysed using the IRF structure, as noted in Chapter 4. The multifunctional nature of moves is also noted. The initiation move (I) is divided into an 'elicitation', 'information', or 'directive' move depending on the function in each turn. The follow up move (F) is divided into an 'acceptance' 'evaluation' and 'elaboration' move. Further information about these moves is provided in the analysis.

Extract 4: Follow up talk about bedside interactions: guiding students to interpret and respond to respiratory abnormalities

Day 2: Red Hospital: corridor Ryoko (student) Glenda (facilitator) Researcher RN	KEY: I= initiation R= response F= follow-up E=elicitation D = directive Inf = information Eval= evaluation Acc= acceptance Elab = elaboration
Stage 1: Finding out what Ryoko noticed	

FRAME: Education			
1	Glenda	could you hear (.) you couldn't hear any sort of (1) the air going into her lungs down here? [*Glenda is asking what breath sounds Ryoko could hear when listening with the stethoscope*]	Initiation/ Elicitation
2	Ryoko	(1) er (1) her (1) right side on her um like yes goes in ((yes)) her like um yes yes goes inside like (1) how do you say more deep (1) deep sound	Response
3	Glenda	right … and then down here. did you hear any[thing	Follow-up/ Acceptance [right] & Elicitation
4	Ryoko	no not much]	R
5	Glenda	down here [*Pointing to her body to show which part of the body she means by 'down here'*] we might have been a bit low there. it's probably easier when she's sitting up um and it was because we were doing it (2) we were doing it below her (*unclear*)	F/ Elaboration
6	Ryoko	yes	R
Stage 2: Following up on patient care with RN **FRAME: Patient care**			
7	Glenda	but (5) um (6) [*Glenda is looking at the notes*]	
8		[*Glenda sees the RN walking by and talks to her about the wheeze they have heard in the patient and how she has noticed the patient has Ventolin ordered– RN says she will check*]	
Stage 3: Explaining clinical thinking (Interpreting) **FRAME: Education**			
9	Glenda	yes okay … the nurse needs to talk to [*the patient*] ABOUT ((yes)) as to whether she should have some Ventolin. (1) if it was just up to me? ((yes)) I would give it. but if it's something that [*the patient*] has (1) on a regular basis she will notice herself whether she needs it or not. okay? ((yes)) so that's why she needs to have that conversation with [the patient]. ((yes)) okay?	I/ Information Check for clarification

10	Ryoko	yes	R
11	Glenda	and what what do you do you know about Ventolin.	I/E
12	Ryoko	no.	R
13	Glenda	okay Ventolin acts on smooth muscle and it relaxes the muscle ((mm)) so that means it relaxes the airway ((mm)) which means that they can take more air in and it's not CONSTRICTED as you're trying to push the air out again ((mm)) because the PROBLEM with um (2) especially asthma but it may be that she's got another airway problem instead of asthma um but with asthma it's because they can't get the AIR out ((mm)) (.) but again I don't know her diagnosis ((mm)) so have you got a handover sheet.	F/Acc [okay] & F/Elab & E
14	Ryoko	yes yes I have [*Ryoko takes out her handover sheet and they look at the information about the patient*]	R
15	Ryoko	[*points out something on the sheet*] um I don't know what's SOB.	I/E
16	Glenda	that's short of breath.	R
17	Ryoko	short of breath? and [*asks about another term on the handover sheet*]	I/E
18	Glenda	peripheral oedema but it's not actually saying to you if she has (*unclear*) if she's got a thing called COPD which is chronic obstructive pulmonary disease? ((yes)) (2) they often need the same medications as asthma? ((mm)) but they may use them at different times to when I would think we should use it ((mm)) so that's why it's really something the nurse needs to ((ok)) think about in relation to her (.) ((mm)) wh-(1) her diagnosis and what's happening with her there at the moment. okay?	R Check for clarification
19	Ryoko	yes.	R
Stage 4: Completing documentation **Frame: Education**			
20	Glenda	um the other thing [*Glenda is looking at the chart*] oh you've PUT THAT IN, not yet. ((yes yes)) you still need to put those in	I/Directive

21	Ryoko	(9) [*Ryoko writes in the chart and reads aloud quietly what she is writing as she writes*]	R
22	Glenda	okay and just if you just put in here again the observations she has … or oh you've done that so [maybe	F/Acc [okay] & I/D
23	Ryoko	I've] NOT done it	R
24	Glenda	oh. okay. okay. so what you'd put? is so 1600 put YOURS in … so the respirations you got? [*they are looking at the chart as they talk*]	F/Acc & I/D
25	Ryoko	respiration [*said while writing it*] (5)	R
26	Glenda	okay. and just (.) just write wheeze.	F/Acc [okay] & I/D
27	Ryoko	(7) *[*(*unclear*) *Ryoko is still writing something*]	R
28	Glenda	so then what you WRITE is. (12) [*Ryoko is still writing something*]	I/D
29	Glenda	write (2) audible wheeze so that means the SOUND that you hear as you're talking to her and also just wheeze (1) on (2) auscultation so that's what you HEARD when you put the stethoscope okay? so if you just write THAT as well. (5) [*Glenda writes audible wheeze and wheeze on auscultation down on her pad and shows Ryoko*] so that's what you're hearing when you hear her speak (.) and wheeze on auscultation. which is with your stethoscope.	I/D
30	Ryoko	(7) [*Ryoko copies the words into the notes*]	R
31	Glenda	that's it! TERRIFIC okay. [*Glenda looks at what Ryoko has written as she says this*] …	F/Eval
Stage 5: Checking Ryoko's understanding of the reasons for correct procedures Frame: Education			
32	Glenda	and the other thing is which I haven't spoken to any of you about is when you're doing your observations and you're doing heart rate. don't just do it on the MACHINES. feel. because do you know what feeling will tell you that the machine can't tell you?	I/E
33	Ryoko	mm.	R
34	Glenda	what sort of things.	I/E

35	Ryoko	er (.) it (*unclear*) sometimes the pulse get faster?	R
36	Glenda	YES	F/Eval
37	Ryoko	and sometimes the pulse get SLOWER.	R
38	Glenda	absolutely (1) so RHYTHM and there's something else it will tell you. (2)	F/Eval & Elab & I
39	Glenda	so it's going bum bum bum bum [*sounds like a strong steady heartbeat*] bum bum bum [*spoken softly and sounds like a weak heartbeat*]	F/Elab
40	Ryoko	um (2)	R
41	Glenda	so what's that what's the difference. (2)	I/E
42	Ryoko	um (.) it's the er (2) the maybe (3 sec) strong or weak.	R
43	Glenda	yes that's EXACTLY right the STRENGTH of it. yes (.) and your machines can't tell you give you that information. that you touching her can. okay! WELL DONE! [*laughter*] I'm going to leave you in peace…	F/ Eval & Elab

Frames and Goals

The above extract has two frames; the first frame is an *education frame* and the second frame is a *patient care frame*. The *education frame* is dominant and both Glenda and Ryoko participate, whereas only Glenda and the RN participate in the *patient care frame*. Ryoko remains a bystander and would not have been able to hear the conversation between the RN and Glenda.

The *education frame* seems to have several goals

- to help Ryoko complete a patient care activity
- to help Ryoko understand the process of making a clinical decision
- to check Ryoko's understanding of the reasons for feeling the pulse when taking a blood pressure reading.

The goal of the second frame, the *patient care frame* seems to be to ensure the patient receives the care she needs by reporting what seem to be abnormalities in the patient's respiratory rate to the RN. However, the two frames interact, as illustrated in Figure 8.

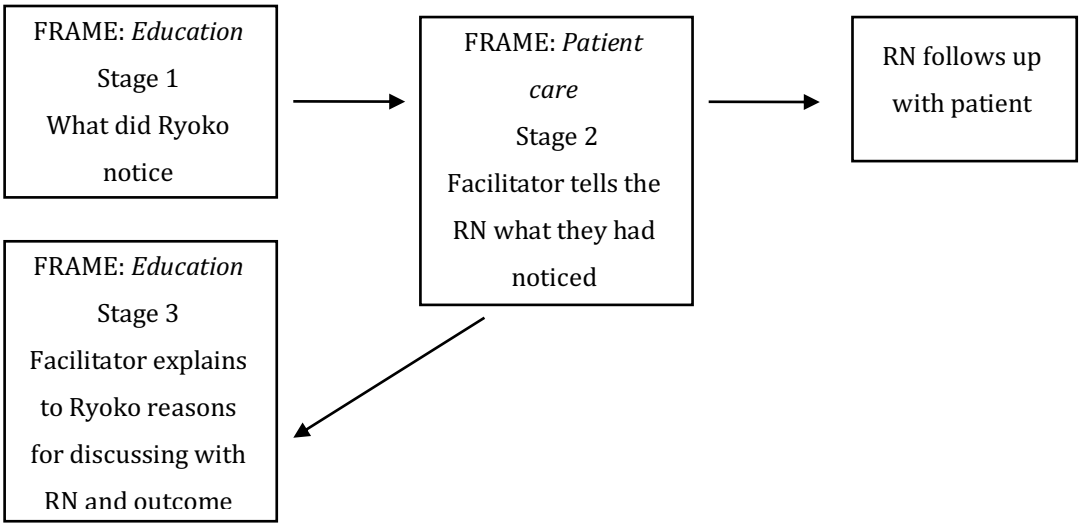


Figure 8: Interdependent frames

In the first stage, Glenda finds out what Ryoko noticed about the patient when she listened with the stethoscope. In the second stage, Glenda 'steps out' of the *education frame* to focus on the patient. She takes into account what Ryoko noticed, checks the written information about the patient in the handover sheet, and then talks to the RN as she walks by in the corridor. In the third stage, Glenda 'steps back' into the *education frame,* noting the shift with a summative discourse marker (the opening 'yes okay' in turn 9) and explains to Ryoko the discussion with the RN, and models some further aspects of clinical decision making. She helps Ryoko to understand how to interpret what she noticed by explaining what they need to think about in order to make sure the patient had received correct care. She also explains why it is important to tell the RN about the patient's results, and what to tell the RN. Finally, in the fourth stage, Glenda helps Ryoko complete the required documentation. In these four frames, Glenda has achieved the goal of helping Ryoko complete a patient care activity and understand the process of making a clinical decision.

In the fifth stage, Glenda's focus shifts away from talking about the patient to checking Ryoko's understanding of the reasons why she should feel the pulse when using a manual blood pressure machine. This stage is not directly related to the previous stages. Rather, Glenda uses this opportunity to check that Ryoko understands a key principle for taking blood pressure. Glenda might expect that

Ryoko would have this knowledge, as it is a topic that has been taught at university. For Glenda, it is not enough that students perform the skill. She wants to ensure they also understand the theory behind the skill.

Participants roles and pedagogic strategies

In all stages except the second, participants are Glenda, Ryoko, and the researcher in a non-participant observation role. In stage two, Glenda interacts with the RN. The expert-novice roles are apparent in all of the stages in this extract. Glenda begins and concludes nearly all of the interactions; she asks questions to check what Ryoko has noticed and to find out what Ryoko already knows. When Ryoko declares her lack of knowledge or clinical skill, or that she has not completed something Glenda presumed she had completed (turns 3 and 13, 24), Glenda accepts this lack of knowledge, skill or action without evaluating it in any way. Ryoko rarely initiates interactions. Glenda uses her expert knowledge as a clinician and as an educator, drawing on a range of pedagogical strategies to scaffold activities, which enable Ryoko to complete the patient care, and Glenda to assess Ryoko's knowledge.

In the first stage of the *education frame*, Glenda adopts an 'asking' strategy and the turn taking structure is a form of IRF. The questions Glenda asks are referential questions, that is questions to which she does not know the answer. She is trying to find out whether Ryoko heard any breathing sounds. Glenda finds out that Ryoko had noticed a 'deep sound' when she listened with the stethoscope. Glenda initiates another question and points to her own body to illustrate where she wants to know if Ryoko heard anything. Glenda follows Ryoko's negative response in turn 5 with an explanation as to why Ryoko may not have heard sounds in one part of the lungs. The overall tone at this point is one of Glenda being curious as to what Ryoko heard. Glenda partly achieves this tone by aligning herself with Ryoko by using 'we' rather than 'you', in turn 5. Potentially, Glenda could negatively evaluate Ryoko's performance at this point, as Ryoko could not have heard if the stethoscope had not been not positioned correctly. By using 'we' to include herself in the action and by softening the explanation with 'might have been a bit low',

Glenda maintained a frame of scaffolding learning rather than a frame of testing knowledge.

Glenda then shifts to a *patient care frame*. She reads the patient notes herself and stops the RN, who is walking by, to report on what Ryoko noticed, and what Glenda has also observed about the patient (turns 7 and 8). Rather than asking Ryoko to talk to the RN, Glenda is in control in this interaction. Ryoko could see but not hear the interaction. It may be that Glenda was concerned about the patient, and wanted to make sure the RN was aware of the patient's wheeze. In intervening and doing things for Ryoko, Glenda seems to have made a judgement that Ryoko was not yet capable of this interaction with the RN. It might also have been a way of time management for Glenda.

In turn 9, the focus returns to Ryoko's learning. In this stage, Glenda helps Ryoko understand the thinking process involved in interpreting what they had noticed in the first stage. Glenda explains to Ryoko the outcome of stage two, which was that the nurse needed to talk to the patient. Glenda explains to Ryoko why she spoke to the RN, and follows with an explanation of the patient's clinical condition. As well as talk, this stage draws on the written handover sheet that contains brief information about the patient. Ryoko would have received this piece of paper during the handover session at the beginning of the shift and was carrying it in her pocket. Again, the turn-taking pattern is predominantly IRF, but in this stage, the function of Glenda's initiations is to give information rather than find out what Ryoko knows. In giving this information Glenda demonstrates how to think like a nurse by explaining that the patient may not have asthma, that it might be another airway problem, and they needed to check information on the handover sheet. She draws on her expertise to help Ryoko notice differences between apparently similar cases (COPD and asthma) which may be treated with the same medication but are different diseases that require different treatment. She also explains why it is necessary to talk to the patient, even if it seems to Glenda, an expert, that the patient needs the medication, Ventolin. Glenda implicitly uses her expertise as a clinician to validate the suggestions she makes as to what 'she would do' or 'if it were just up to me'.

In this stage Ryoko's participation is minimal: she confirms she has understood in turns 10 and 19; and she responds to Glenda's question in turn 12 with 'no'. She initiates only two turns in 15 and 17 to query the meaning of two abbreviations. In contrast, Glenda's turns are relatively lengthy, consisting of multiple clauses. It seems in turn 11 that Glenda was going to ask an open question 'what do you know about Ventolin' but changed this to a closed question, 'do you know about Ventolin?', which allowed Ryoko to give a minimal response, 'no', a response that Glenda accepts without any evaluation (turn 13). Glenda may have initially thought that Ryoko knew something about Ventolin, as it was part of the university curriculum. However, her shift to a closed question may have been a time management strategy, or Ryoko' s minimal responses so far may have indicated it would have been challenging for Ryoko to explain Ventolin. Glenda's moves in the rest of the interaction elaborate on Ventolin, specific respiratory diseases and link this back to what they had noticed about the patient. Glenda's talk demonstrates for Ryoko critical reasoning as a nurse. By thinking out loud (Eggins 2016; Spouse 1998b), Glenda demonstrates the importance of questioning assumptions, checking the diagnosis and making sure the care is specific to the patient. In this stage, Glenda's pedagogic strategy is similar to what Eggins (2016) calls 'demonstration'.

In stage four Glenda drives the interaction to help Ryoko complete the documentation of patient care. The turn taking pattern here is again IRF but Glenda's initiations are mainly directives, a call for Ryoko to take action (Mehan 1979, p. 49). Most of Ryoko's turns are repeating words to herself as she writes down the words that Glenda provides; 'audible wheeze' and 'wheeze on auscultation'. Whilst Ryoko is a novice, Glenda offers her opportunities to complete activities before providing more support, working in Ryoko's zone of proximal development by judging when Ryoko is not yet capable of completing the activity alone. Glenda leaves lengthy pauses to give Ryoko time to write on the chart. She leaves a 12 second pause in turn 28, during which Ryoko continues to document something, but when Glenda notices that Ryoko had not written about the wheeze, Glenda tells her the words to write, and explains what they mean:

'write audible wheeze and that means the sound you hear as you're talking to her and also just wheeze on auscultation so that's what you heard when you put the stethoscope'. Again, Glenda leaves a 5 second pause, but Ryoko does not begin to write so Glenda demonstrates what to write by writing in her notepad and Ryoko copies. Rizan et al. (2014) refer to the use of silence as an opportunity space. In their study, after students had provided an incorrect answer, the supervisor used silence to allow students an opportunity to self-correct. Whilst Glenda at times also used silence to indicate that students had given an incorrect response, here Glenda uses silence as an opportunity space to find out whether Ryoko can provide an answer. Then, if Ryoko does not speak, Glenda gives a directive. The extract illustrates how Glenda judges when Ryoko has reached the limits of her knowledge, and adjusts pedagogic strategies, in order to provide increasingly explicit guidance. Glenda's strategies of firstly, using silence as an opportunity space for Ryoko to complete a task, and then following up with verbal and visual directives, enable Ryoko to complete documentation of patient care.

The goal of the fifth stage seems to be to check Ryoko's knowledge of the reasons for feeling a patient's pulse. Glenda introduces the topic by telling Ryoko to not just use the machine when doing observations but to feel, asking if Ryoko knows what 'feeling will tell' her that the machine cannot. By feeling (or later 'touch'), Glenda is referring to the act of placing fingers on the patient's pulse in order to feel the strength of the pulse. As Glenda's first elicitation was a closed question, what Mehan calls a choice elicitation (1979, p. 44), Ryoko indicates that she knows by saying 'mm'. However, Glenda follows up by asking an open question, 'what sort of things' to confirm that Ryoko does know. This is what Mehan (1979, p. 44) refers to as a product elicitation as it requires a factual response from the student. Ryoko gives the correct response that sometimes the pulse gets slower or faster, which Glenda reformulates as 'rhythm'. She then prompts Ryoko for a second reason, firstly using silence as an opportunity space for Ryoko to provide a response, and when there is no response, providing two prompts. The first prompt is that there is another reason, and then when Ryoko does not respond, Glenda provides a hint. She tells Ryoko what the noise sounds like and prompts her to think of the difference in the noises. Ryoko guesses that maybe the

difference is strong and weak and Glenda reformulates Ryoko's words to 'the strength' and recaps that machines cannot provide nurses with that information (rhythm and strength), but touch can. Here Glenda uses an extended IRF structure (Mehan 1979, p. 54) as supportive scaffolding (Saxena 2010, p. 166), using prompts and hints to 'lead students to the edge of the answer … rather than providing them with the answer'. Part of this supportive scaffolding is to help Ryoko learn the terminology of the discipline, which Glenda does by recasting everyday language ('slower and faster' to 'rhythm' and 'strong and weak' to 'strength') into technical terms (Cullen 2002; Edwards & Mercer 1987; Gibbons 1998). Glenda withholds her evaluation until she gets the correct answer. The above interaction is represented in Table 17 below.

Table 17: Asking: prompting, hinting and reformulating

G= Glenda, facilitator R=Ryoko, student

			Initiation	**Response**	**Follow-up**
32	G	and the other thing is which I haven't spoken to any of you about is when you're doing your observations and you're doing heart rate. don't just do it on the MACHINES. feel. because do you know what feeling will tell you that the machine can't tell you?	*Choice elicitation* (requiring only a yes/no answer)		
33	R	mm.		*Minimal response*	
34	G	what sort of things.	*Product elicitation*		
35	R	er (.) it (*unclear*) sometimes the pulse get faster?		*Partial response*	
36	G	YES			*Evaluation*
37	R	and sometimes the pulse get SLOWER.		*Partial response*	
38	G	absolutely (1) so RHYTHM and there's something else it will tell you. (2)	*Repeat product elicitation*		*Evaluation*
39	G	so it's going xx [*sounds like a strong steady heartbeat*] bum bum bum [*spoken softly and sounds like a weak heartbeat*]	*Repeat elicitation with prompt*		
40	R	um (2)		*No response*	
41	G	so what's that what's the difference. (2)	*Repeat elicitation with prompt*		
42	R	um (.) it's the er (2) the maybe (3 sec) strong or weak.		*Response*	
43	G	yes that's EXACTLY right the STRENGTH of it. yes (.) and your machines can't tell you give you that information. that you touching her can. okay! WELL DONE! [laughter] I'm going to leave you in peace…			*Evaluation and follow up repetition of key teaching point*

Dynamic pedagogic strategies

Glenda can be seen to use a range of pedagogic strategies to help Ryoko complete this patient care activity, as shown in Table 18 below. The table illustrates which frame was prioritised at each stage of the interaction.

Table 18: Pedagogic strategies to complete patient care

	Frame: Education	**Frame: Patient care**
Stage 1	Asking: to find out what Ryoko knows/noticed	
Stage 2		Intervening and acting on behalf of the student**:** doing and talking for the student
Stage 3	Telling: to model thinking and to explain terms	
Stage 4:	Telling: to give directives to complete a form	
Stage 5	Asking: to guide Ryoko to the correct answer	

Each of these strategies seems to have been adopted depending on the goal Glenda was trying to achieve, and what level of competence she judged Ryoko to have at that point. In stage 5, Glenda makes a judgement that this knowledge is within Ryoko's capability and uses a strategy of prompting until she reaches the correct answer, whereas in stage three she seems to have decided that Ryoko did not have knowledge of the different respiratory conditions and medication, and provided her with that information. Glenda uses silence as a strategy in stage four to try and find out what level of knowledge Ryoko has and then adopts a 'telling' approach giving directives what to write, as Ryoko does not respond to the silences. Glenda's choice of which strategy to adopt may also have been influenced by the location of the interaction. Although Glenda and Ryoko were standing aside from the daily interactions in the corridor, Glenda's decision to tell the RN what was happening in stage two may have been based on a time management decision as well as a judgement that Ryoko was not capable of doing this. It was important to catch the nurse as she hurried by and to quickly pass on the information.

Glenda also seems to adopt some strategies that are particular to Ryoko being an EAL student. In this interaction, Glenda does a lot of the work, which may be appropriate as Ryoko is a first year EAL student. Glenda helps Ryoko by speaking

slowly and clearly and leaving pauses for Ryoko to speak (note the five second pause in turn 25, which she left when she asked Ryoko to fill in the chart about respiration). Glenda seems to have judged from Ryoko's non-verbal and verbal responses when Ryoko was unsure and provided her with more support, for example, by writing words for her in the chart the first time and on a pad the second time for Ryoko to copy into the chart. However, the teaching strategies adopted by Glenda also mean that Ryoko can complete the activity with minimal language. By setting up the activity with the patient and by reporting to the RN for Ryoko, Glenda reduced the need for Ryoko to engage in extended talk. The questions Glenda asked during the interaction were useful in helping guide Ryoko's knowledge. However, the interaction pattern may also have limited Ryoko's opportunity to talk, as the IRF pattern that Glenda established restricted Ryoko's contributions to responses to Glenda's questions (Mercer 1995). Nevertheless, in the corridor space, where time is limited, where the documentation needs to be completed and where patient safety is of concern, Glenda's strategies seem to have been successful in that Ryoko was able to participate in this activity and to complete the chart.

Participant relations: attitude

Although clearly in an expert/teacher role, Glenda seems to be mindful of the power differential in their positions and moderates her instructions and corrections to reduce this power relationship. Although Glenda was concerned enough about the patient's respiratory condition to ensure that Ryoko checked it a second time, she couches her instructions in the language of advice. In giving initial instruction, she said to Ryoko, 'I would go back in ten minutes and I would do her respiration'. Glenda here spoke as an expert clinician who knew what to do in this situation. 'I would do this' is not a clear instruction but is probably meant as an instruction. When explaining that Ryoko may not have heard noises because she had the stethoscope in the wrong place, Glenda mitigates the correction by saying, 'you might have been a bit below there' rather than 'your stethoscope was too low' and she includes herself in the correction 'it's because we were doing it we were doing it below'. Glenda repeatedly gave indirect instructions throughout the placement. She made suggestions and talked about what she would do. It was

rare for her to give direct instructions unless she was concerned that something had gone wrong. Towards the end of the two- week period, when she was concerned that Ryoko had given a patient incorrect information prior to being discharged, I noticed that Glenda gave a very clear instruction to Ryoko. This moment occurred when Ryoko told Glenda that she had not instructed a patient to wash his finger before taking his blood sugar level. Glenda responded

> Glenda: you must tell him to wash his finger. ((okay)) before he does his blood sugar ((okay)) it is ABSOLUTELY essential ((okay)) okay? it is very dangerous if he doesn't because if he has any sugar ((mm)) on his fingers ((yes)) (.) it will read high a higher than what his real blood sugar is ((oh right)) okay? … you HAVE to wash it with water

When I talked to Glenda about the use of this direct instruction she said it was because the patient was going home and it was important that he knew the correct procedure. In such instances, patient safety was prioritised over reducing power relations.

Glenda also helps manage the power differential by building up a relationship with Ryoko by talking about Japan and by asking about her previous work. In talking about her own experience with Japan, Glenda creates a co-membership (Erickson & Shultz 1982) with Ryoko, establishing something they have in common. Glenda slips these relationship-building interactions into her daily meetings with students. Establishing a relationship between facilitator and student is of fundamental importance, and has consistently been found to contribute to positive student placements (Eyre 2010; Mikkonen et al. 2016a).

Learning opportunities

In this interaction, Glenda has modelled for Ryoko important steps in the process of clinical reasoning, which can be related to Tanner's (2006) model of clinical judgement. These steps are summarised in Table 19 below.

Table 19: Modelling clinical reasoning

	Glenda's stages	**Tanner's model of clinical judgement (2006)**
Stage 1	Finding out what Ryoko noticed about the patient	Noticing
	[*Glenda reads the notes and makes a decision to tell the RN*]	Interpreting
Stage 2	Talking to the RN	Responding
Stage 3	Explaining what the RN needs to think about and what Glenda would do	Interpreting

In explaining her reason for talking to the RN and the patient's medical condition, Glenda models the process of interpreting signs and symptoms. Erickson (1999) argues that encounters like this provide opportunities for students to appropriate the professional discourse through indirect teaching and joint participation in an activity. However, as Glenda's modelling of clinical judgement is implicit, and as Ryoko participated minimally, the extent to which Ryoko understood the clinical thinking process in the above interaction cannot be assessed. Nevertheless, Ryoko had opportunities to learn about medical conditions and treatments; Ventolin and what it is used for; and technical terms for things she saw and heard, for example 'wheeze on auscultation', which enabled her to complete documentation. Completing documentation is one of the forms of institutional discourses (Shrubshall & Roberts 2005) that students need to learn.

Assessment opportunities

Whilst Glenda clearly controlled the interaction, Ryoko responded to Glenda's questions when she could. However, she used few words, often responded with 'mm' and needed prompting by Glenda to elaborate on her responses. Her responses were spoken very quietly. She hesitated, as indicated by several pauses and hesitations (um), and did not know quite a lot of information. She had not understood the handover sheet, did not know what Ventolin was, nor how to write about respiration in terms of shortness of breath and wheezing sounds. As this was only the second day, her lack of knowledge was not unusual. The handover sheet had many specialised medical terms with which students were not likely to be familiar. However, students were expected to ask if they did not

understand, and Ryoko did point out to Glenda that she did not understand what was written about the patient on the handover sheet. Interactions like this one with facilitators offered the opportunity to find out what some of these terms meant.

Although Ryoko seemed quiet, and hesitant with her spoken language, in the bedside interaction prior to this *follow up talk on a bedside interaction*, she did seem quite confident in caring for the patient, and in undertaking the clinical task. She used the stethoscope confidently and followed Glenda's instructions. Ryoko had already correctly completed some of the chart with information about observations before Glenda helped her with the more difficult charting of respiration. In stage five, she also found out that Ryoko understood the significance of feeling the pulse. Glenda gave Ryoko positive feedback for this interaction. It may have been Ryoko's confidence in these clinical skills, as well as her ability to complete clinical tasks with Glenda's support that led to Glenda assessing Ryoko as independent for communication at the end of the first week, meaning that Ryoko was not considered to require further support. However, Glenda began to question this decision in the second week when she had spent more time with Ryoko, particularly in the context of reading patient notes (see Chapter 9 for discussion of this activity).

The above analysis illustrates how the facilitator guides a novice student to think critically and clinically about her patient care. The student seemed to require extensive scaffolding to help her reach the correct answer. The next extract illustrates how the same facilitator interacts with a student who seems more confident in both her nursing knowledge and her English language performance.

Follow up talk about bedside interactions: extending students' critical thinking about patient care

Setting and access

On Day Eight, Glenda observed Soo-jin in the patient room, as she took a patient's vital signs. This interaction was discussed in Chapter 7. After Soo-jin had

completed the vital signs, Glenda directed Soo-jin to the corridor, (the same location as described and illustrated above for Ryoko), and I stood with them. The extract below is taken from the conversation that occurred in the corridor between Glenda and Soo-jin. It illustrates how Glenda adapted her pedagogic approach to respond to a student who initiated turns and focal themes in the *feedback on observation* activity. In this extract, Glenda helps extend Soo-jin's learning and confirms that Soo-jin is thinking critically as a nurse. Whereas in the previous interaction, Glenda guided Ryoko through the clinical reasoning process, in this extract, Soo-jin illustrates that she is already thinking through the steps of clinical reasoning in her description to Glenda of what she had done with a patient that day. Again, the interaction is analysed using an IRF framework, except for stage 3, which does not follow an IRF pattern.

Extract 5: Follow up talk on bedside interactions: extending students' critical thinking about patient care

Day 8: Red Hospital: corridor Soo-jin (Sj) (student) Glenda (G) (facilitator) Researcher		**Key** I= initiation R= response F= follow-up E=elicitation D = directive Inf = information Eval= evaluation Acc= acceptance Elab = elaboration	
Frame: Education: Stage 1: Extending Soo-jin's knowledge [of medications]			
1	Sj	[*Sj tells G her difficulties in remembering medications]*	Initiation - comment
2	G	*[G advises Sj to check dosage and side effects of medications by consulting drug manual, rather than just relying on doctors' orders. G asks Sj what she would do if she saw that one of the side effects of a medication was dizziness*]	R & I/Elicitation
3	Sj	I think I would ask for assistance whenever he wants to go to toilet or?	Response

4	G	(.) WELL DONE! FANTASTIC!	Follow-up/Evaluation
5	Sj	alright?	Confirmation request
6	G	fantastic, that's absolutely what I was looking for! [*said in an excited tone*]	F/Eval
7	Sj	oh thank you [*laughs*]	
8	G	WELL DONE yes because you can never guarantee that he may not (.) pass out if he suddenly finds himself dizzy because of this drug ((mm)) and he's already got a low blood pressure ((mm))	F/Eval & Elaboration
Stage 2: Following up on patient care: thinking critically **Frame: Education:**			
9	Sj	so the nurse told that if we do check the blood pressure if it's lower than 90 ((mm)) I have to call (*unclear*) right away so they can call the doctor ((mm)) for checking ((yes)) (.) but one of the patients was kind of different because her heart rate was really really low. the doctor write down some itemations on her observation chart? ((yes)) so if it go lower than 35 need to call the doctor but if it's more higher than 35 it's totally fine for HER but whenever she was moving it was normal but if she relax and then lying on the bed it was really low 40 or 50 and I was shocked and I just told the nurse and then she said just (*unclear*)	Initiation
10	G	yes absolutely no its good that you did what you did because even if it had that criteria there. it's important that you let your nurse know. ((mm)) because even if their observations are normal if you tell your nurse (.) then it means that he or she is then always aware of what's happening to their patient ((mm)) okay? ((alright)) so just just let them know each time. was this patient athletic? like plays lots of sport?	F/Eval & Elab & I/E
11	Sj	[2] the lady?	Clarification request
12	G	with the very low pulse	Clarification given

13	Sj	no I didn't find any information about that and she was just there for one day? ((right)) so I didn't have a chance to look again ((yes)) but she was very skinny um	R
14	G	she may have been an athlete when she was younger	I/Inf
15	Sj	ah maybe!	R
16	G	because people who are athletic have a very [low heart rate	I/Inf [cont]
17	Sj	low heart rate]	
18	G	and then as you said it comes to normal when they [start moving	I/Inf [cont]
19	Sj	start]	
20	Sj	ah because when I checked it one hour ago it was around 40 and then she just went for some regular walk with her friend and then when I checked it around 90 so I thought is that machine is broken so I just checked manually and it was correct and she said that she just went for walk ((right)) and but the mine was kind of like this fluctuate so I again go to nurse you know her pulse first it's like this at the moment it's (*unclear*) the nurse asked me whether she was moving a little bit I said yes she said that's fine [*laughs*] mm that's interesting our body is REALLY REALLY amazing I think xxx	I
Stage 3: Giving a formative assessment **Frame: Education:**			
21	G	and so what I just wanted to say you know in your assessment form it talks about critical thinking.	
22	Sj	mm yes.	
23	G	as I'm talking to you and listening to what your answer is it shows to me you're critically thinking about what you're doing ((oh.)) and how like that drug could impact that medication could impact on say in regard to//	
24		//medication	
25	G	to him being the risk of being dizzy and the risk with him mobilising ((mm)) that's all really important thinking okay	
26	Sj	if you ASK ME maybe I can think about it but if you don't ask me maybe I'm not going to think about it ((ah!)) that's the trick	

27	G	ah! [*both laughing]* so what we're going to be teaching you over the next three years or only two more years is that you take that step further and think about it for yourself	
28	Sj	yes. that would be great [*laughs*]	
29	G	*[G mentions two other things she noticed when Sj was taking vital signs. She points out that when putting the clip on the patient's finger to check the oxygen saturation she turns the clip the opposite way than Sj did, and she points out the design of the clip which suggests it should be this way. She softens this by saying 'I don't know if it makes a difference'.*	
Stage 4: Checking Soo-jin's knowledge of correct procedures **Frame: Education**			
30	G	and the other thing when you did the blood pressure I missed did you actually FEEL and pump up ((yes)) and let it down and then put the stethoscope on.	I/E
31	Sj	ah! you know first time when I checked it I just checked the pulse ((yes.)) how far can I push up	R
32	G	yes that's right.	F/Acc
33	Sj	so I just checked the pulse and then I didn't feel any pulse. and then I stop it and ((yes)) then I just release the air ((yes)) and then I put the stethoscope	R
34	G	fantastic that's good//	F/Eval
35	Sj	//that's what I did	R
36	G	yes I just thought I missed it ((ah)) and I just wanted to check whether you did that or not	F/Acc [yes] & F/Elab
37	Sj	but if I just have a question I already know the patient and I know the range so I don't want to bother them again to check the pulse all the time so if I know a patient is it okay to push the normal range I already know? or every time I have to check it the pulse.	I
38	G	the problem is if the patient let's say is on	R
39	Sj	some medication//	
40	G	//some medication ((yes)) be it [*name of medication*] or be it an anti-hypertensive ((mm)) and then the drug is wearing off	R

		if it's an antihypertensive ((mhm)) and if you think oh I know what their previous//	
41	Sj	//range	
42	G	range is	
43	Sj	but	
44	G	it means its higher ((higher)) and you may miss it	R
45	Sj	mm so if I push too much they can have some bruise?	F/Acc & I/E
46	G	that's right	R
47	Sj	oh but if I'm using the automated one I don't need to worry about it but when I'm doing manual one I've got to check it every time?	F/Acc & I/E
48	G	yes.	R
49	Sj	okay	F/Acc
50	G	the automatic the problem is it pumps up really high	F/Elab Inf
51	Sj	I didn't think that mm yes	F/Acc
52	G	but you did that very well that was yes very good	F/Eval

Frames and Goals

This interaction has only one frame, an *education frame*. Glenda seems to have two goals in this frame. Firstly, she ensures that Soo-jin is thinking critically about her nursing practice. Secondly, Glenda checks Soo-jin's procedural knowledge, confirming that Soo-jin understands how to take a blood pressure correctly, and why it is necessary to follow certain procedures when doing so. Apart from wanting to demonstrate the requisite skills to the facilitator, Soo-jin may have other goals for this interaction. In stage one, she seems to be seeking advice on something she finds difficult (remembering medications), and in stage two, she seems to be checking about something she has found troubling in her patient care (caring for a patient with an abnormally low blood pressure).

Participants roles and pedagogic strategies

The expert-novice roles are again apparent in this extract. However, here, Glenda does not always control the interaction, and Soo-jin has extended turns at talk. Soo-jin initiates the topics discussed (turns 1, 9); she picks up on the topics

Glenda introduces, and then applies the new points raised by Glenda to her current patients (turn 20); and she demonstrates her understanding of what Glenda tells her, by asking further questions that extend Glenda's explanations (turns 45 and 47). Whereas in the previous extract (extract 4), Glenda used talk to help Ryoko interpret and document what she had noticed, Soo-jin leads this interaction, raising concerns about things she has noticed while undertaking patient care. The topics Soo-jin raises are not directly related to the patient-student interaction Glenda has just observed but are related to other patients in that room that Soo-jin has been caring for. Glenda uses talk to check Soo-jin's knowledge, extend her knowledge in terms of medication safety, to praise her performance, and confirm that she is thinking critically.

This interaction between Glenda and Soo-jin has four stages. Although the first two of these stages are topics initiated by Soo-jin, Glenda established favourable conditions for Soo-jin to initiate questions by staying with her after observing her in the patient room, and suggesting they walk into the corridor for a chat. Glenda makes it clear that she has time to spend with Soo-jin by: walking slowly, and by standing with Soo-jin; and by speaking slowly, leaving silences that offer opportunities for Soo-jin to initiate topics. Soo-jin uses this corridor space to draw on Glenda's expertise and find out what she wants to know. In the third stage, Glenda initiates the interaction by providing an overall formative assessment based on the previous two stages. In the fourth stage, Glenda returns to the interaction she had observed in the patient room when Soo-jin took a patient's blood pressure. Glenda checks with Soo-jin that she had carried out the procedure correctly by following a two- step process (feeling the pulse and estimating the blood pressure before pumping up the cuff).

The participant roles are dynamic in this extract. In the first stage, Soo-jin initiates a general concern she has in remembering the names of medications. Rather than focusing on the difficulty of remembering or reassuring her that she will become familiar with time, Glenda responds by extending the topic to discuss the role and responsibility of nurses in safe administration of medications. Glenda could have asked Soo-jin a more open question, for example, 'what do you know about the

correct procedures for administering medication' to find out what Soo-jin knows. However, Glenda narrows the focus of the interaction by limiting the discussion to the correct dose and the side effects of medication. This limited focus may have been a time management strategy for Glenda to keep the interaction shorter. Glenda uses a typical IRF structure to find out how Soo-jin thinks critically about patient care, by asking what she would do if dizziness was a side effect. The question is a display question. Soo-jin demonstrates her knowledge by responding correctly (turn 3), and is praised by Glenda with 'well done', 'fantastic', 'that's absolutely what I was looking for' and 'well done' again (turns 4, 6 and 8). Glenda uses this situation to build on a topic Soo-jin raises, to find out what Soo-jin knows about medication safety, and what she would do in a given situation. Glenda is pleased with Soo-jin's performance. Soo-jin demonstrated her positive relationship with Glenda when she extended the IRF structure by inserting a sequence in turn 5, in order to check that she is correct. In turn 7, Soo-jin inserts a thank you in reply to Glenda's confirmation that Soo-jin was indeed correct. These two insertions, asking for reassurance that she was correct, and thanking the facilitator for a positive evaluation, clearly indicate that Soo-jin is positioning herself as a student, and acknowledging the expertise of the facilitator. Glenda's follow up in turn 8 demonstrates the reasoning behind the correct answer that Soo-jin provides.

Soo-jin initiates the second stage by picking up on the topic of low blood pressure that Glenda mentioned in completing the first stage, and raises a second concern she has, this time about a specific patient who has low blood pressure. Whilst this stage has elements of an IRF structure, the interaction pattern is more dynamic than the previous stage. Soo-jin initiates the interaction (turn 9), illustrating that she is aware of the standard procedures for reporting low blood pressure but wants to clarify a particular situation she has with one of her patients who had very low blood pressure. Glenda's response is, firstly, an evaluation (turn 10), reassuring Soo-jin that she had taken correct action, even though according to the patient notes there was no need to inform the doctor. Then she follows up by elaborating on why it was the right thing to do (turn 10). Here, what is important is that Soo-jin is a student and is not responsible for patient care. However, Soo-

jin needs to keep the RN, who is responsible, informed about patients' conditions. Finally, in this turn Glenda initiates a new line of thinking, asking if the patient is athletic. Glenda drives the next section of this stage (from the end of turn 10 to turn 18), explaining why a patient's history of being an athlete may affect blood pressure. Glenda here demonstrates (Eggins 2016) thinking like a nurse by considering the reasons why apparently abnormal readings may be considered normal for this particular patient. Soo-jin responds to indicate her understanding by back-channel agreements (right; mm; yes; ah maybe) and in the final turn of this stage (turn 20) by returning to the story of the patient she had introduced in turn 9 and elaborating on the reasoning Glenda provided. In elaborating on this reasoning Soo-jin also relates that she noticed the abnormal readings, checked the reading by repeating the blood pressure, and reported the reading to a nurse.

In the third stage, Glenda gives a formative assessment to Soo-jin, praising her, for her critical thinking. Soo-jin's performance in this stage and the previous one has shown Glenda that Soo-jin was assessing her patients' health status, was able to interpret that status, plan follow up actions, and inform other relevant staff. Soo-jin's response in turn 26 that she only thinks like this, if Glenda asks her, suggests that Soo-jin found this style of teaching effective. It also however may be a way of Soo-jin acknowledging the role of the facilitator as expert, taking up a position of a polite student who appreciates the facilitator's feedback.

It is only in stage four of this extract that Glenda returns to talking about Soo-jin's bedside interaction with the patient. In this stage, as in the final stage of the previous extract (no. 4), Glenda's goal seems to be to check that Soo-jin understands the correct procedure of taking blood pressure. However, unlike the previous extract, where Glenda led Ryoko to the correct answer as to what feeling the pulse could tell her, in this extract Soo-jin does more talking than Glenda. As in the previous extract, Glenda opens with a choice elicitation 'did you feel and pump up and let it down'. However, whereas Ryoko had responded with only 'mm', Soo-jin here explains what she did and Glenda provides an evaluation (turn 34). In the equivalent stage in the previous extract, Ryoko was in a responsive role. In this extract however, Soo-jin disrupts the teacher-controlled IRF pattern, as she

initiates in turn 37, asking Glenda if it is always necessary to estimate the patient's blood pressure. Glenda responds and again Soo-jin checks her understanding twice, in turn 45 and in turn 47.

The laughter shared between Soo-jin and Glenda, as well as the dynamic pattern of interaction suggest a relaxed atmosphere exists between Glenda and Soo-jin. Soo-jin seems to be comfortable initiating interactions, as well as responding to Glenda's elicitations, and Glenda allows Soo-jin to 'share the power' and 'negotiate the 'management of talk'' (Saxena 2010, p. 172). Although the relationship is still that of expert novice, Soo-jin takes an active role in using the corridor space to find out what she wants to learn from Glenda.

Learning opportunities

In this *feedback on observation* activity, Soo-jin had opportunities to learn how to think about the side effects of medication and what actions to take to prevent those side effects. She had opportunities to think like a nurse in considering reasons why a patient might have abnormal readings. Finally, she learned that as a student she had followed the correct procedures in telling the RN about her patient. Soo-jin also learned about her own performance as student. From Glenda's positive feedback, it is clear that she was performing in a way that was expected of her.

Assessment opportunities

In this activity, Soo-jin demonstrates to Glenda that she is reporting to the nurse when she thinks there was a problem with patient results (turn 9); she is thinking about the effects of medication and the impact on patient care (turn 3); and she is using the right equipment to recheck patient results when she thinks there is a problem (turn 20). She also demonstrates that she understands Glenda's explanations by elaborating on them. Soo-jin demonstrates that she is beginning to think like a nurse, using a process of clinical reasoning by noticing, interpreting and responding, and finally by engaging in reflection on this process with her facilitator.

Whereas Glenda did most of the work in the interaction with Ryoko, Soo-jin participates more extensively. Soo-jin's confident performance could be because

the interaction took place on the eighth day, by which time she had had time to build up a relationship with Glenda and had participated regularly in patient care activities. She seems confident in raising topics and in contributing her ideas. In terms of her English language performance, Soo-jin appears to be much more confident than Ryoko. She asks for clarification. She demonstrates understanding by giving back channel comments and by elaborating on responses and by picking up topics. When asked questions, she contributes more than minimal answers required, for example, when asked if the patient was an athlete, she did not know but she added information that she was 'skinny'.

The corridor as a learning space

Ad hoc encounters in the corridor have been described as 'the most underestimated yet probably … the most unique teaching opportunity' in clinical supervision (Molodysky 2007, p. 1046). They provide opportunities for teaching that is situated, just in time, and that helps novices become part of the community of practice (Eggins 2016). The extracts in this chapter demonstrate that Glenda's use of the corridor as an educational space differs somewhat from that previously noted in the literature. One key difference is Glenda's structured approach to the activities in the corridor, which contrasts with the ad hoc nature found in Morrison et al. (2014) and Pearce (2003). Whilst initial observations in the patient room may have happened opportunistically, the *follow up talk* was deliberate. Furthermore, rather than being integrated in some way to the on-going work of the ward as in Eggin's (2016) study, Glenda uses the corridor as a 'retreat' from the ward, where students can step aside from the patients and other healthcare professionals, and put being a learner at the forefront of their interaction with facilitators. The corridor is reproduced as a learning space, where the clinical facilitator and students can focus on a clinical event but where the main aim of the activity is now student learning, rather than patient management or diagnosis. Patient diagnosis and management are certainly referred to in these encounters, as in medical encounters reported by Morrison et al. (2014), but they are not the main goal of the activity. Rather, the purpose of the interaction is to help students think beyond the skill they had performed to what they had noticed

in performing the skills and how to interpret what they had noticed. The frame is clearly one of *education.*

In research that focused on interprofessional interactions in clinical settings, Iedema et al. (2006) draw on Goffman's concepts of frontstage and backstage to interpret why the corridor plays an important role in communication. They propose that clinicians regard corridors as backstages, which are away from the frontstage of the clinical ward and the patient room, and therefore allow the performance of different selves, allowing for informality and talk that does not produce the usual hierarchical relationships among clinical staff. In my study, where students participate in an *education* as well as a *patient care frame*, students experience the corridor as frontstage. In the corridor, facilitators and students can prioritise the *education frame*, allowing for talk that focuses on student learning rather than talk that focuses on completing a patient care activity. Unlike the clinicians in Iedema et al. (2006), students rarely have a 'backstage' place. When performing as students, hierarchy continues with the teacher-student relationship, and students are aware that assessment, as well as learning is occurring, as illustrated in extract 5 when Soo-jin asks Glenda if she has given the correct answer.

The corridor space is important as, whilst in front of the patient, students need to project an identity that is professionally confident so that patients will allow them to practise their skills. Spending too long questioning a student in front of a patient may instead project a novice identity. On the other hand, in the corridor, the facilitator can use interactional strategies that help guide students' thinking, taking the time to talk through the activities observed, find out what students know, build on that knowledge and correct where necessary. These interactions seem to combine what Spouse (1996) referred to as sense making and coaching. The facilitator guides students to make sense of the activity in which they participated. At the same time, these corridor interactions provide opportunities for facilitators to assess students' clinical competency and English language performance.

This learning space of the corridor seems particularly beneficial when sequentially linked to the learning space of the patient room. A move to the corridor away from the bedside and away from the other healthcare professionals is essential for extended learning moments (Rizan et al. 2014, p. 915) where facilitators can guide students' learning on focal themes arising from the clinical activities they had undertaken in the patient room. Whereas in the patient room, students need to manage multiple frames, which may contribute to minimal talk by students, in the corridor there is usually only an *education frame.* Furthermore, whereas the goal of the activities in the patient room is to complete patient care in a timely, safe and comfortable manner for the patient, in the corridor it is to ensure students have understood the care they have given, and the follow up steps that need to be taken. In the patient room, interactions are often action-oriented and students can at times complete tasks with minimal talk. In the corridor, however, talk is central to the activity.

By remaining in the corridor, rather than retiring to another room, facilitator and students remain close to the action, and are still in sight of the other nurses on the ward. Glenda had mentioned to me that university guidelines on facilitation stipulated that she was not supposed to take students off the ward for long periods of time. Using the corridor in this way integrates learning spaces into students' daily routines. There are of course potential problems with such corridor conversations. One issue is the challenge of maintaining patient confidentiality when talking about patients in a public space. However, in the cases I observed, Glenda and the students did not refer to patient names in these conversations. A second potential problem for students, especially EAL students, is the background noise itself. Frequent beepers, buzzers and rattling trolleys can be distracting, corridor conversation can be hurried, and there may be misunderstandings. However, Glenda creates a space that addresses these potential problems by creating a private learning space within a public space, drawing on existing resources such as hospital trolleys or doorways to create focal points, by speaking slowly, and by allocating time to interact with students. This contrasts with the previously studied corridor teaching literature which stress the busy, hurried nature of corridor interactions (Eggins 2016).

Previous literature on pedagogic style in medical education, with and without the patient, have focused on teaching strategies used by supervisors and on how these teaching moments fit within the daily routines. The present study adds to the few empirical studies that focus on analysis of the discourse of teaching and learning in healthcare contexts (Ajjawi, Rees & Monrouxe 2015; Eggins 2016; Erickson 1999; Rizan et al. 2014). As mentioned previously, Eggin's (2016) study refers to senior doctors' use of strategies as demonstrating, declaring and eliciting. Glenda's pedagogic strategies can be classified in similar ways. What is noticeable about Glenda's use of these strategies is that they are fluid, dynamic and contingent on the focal themes and on the responses of the student. Contingency refers here to how Glenda responds and adapts her teaching according to the interaction (van Lier 2001: Mercer 1995). Contingency has mainly been considered in classroom situations rather than dyadic interactions but is relevant here as the extracts illustrate how Glenda's combination of both planned activities and a contingent approach provides opportunities for students to learn and to be socialised into the ways of thinking, talking and documenting like a nurse. Gibbons (1999, p. 37) argues that 'moment-to –moment contingency [is related to] broader levels of planning'. The broader planning she refers to is the school curriculum. Glenda's broader planning takes into account the university curriculum and the assessable skills listed on the students' clinical assessment. However, Glenda's broader planning also relates to the seemingly deliberate use of space and allocated time for student learning in the corridor.

It has been argued that corridor encounters are difficult to schedule because of the 'the unpredictable, fluid, spontaneous, and reactive context of ad hoc GP supervision' (Morrison et al. 2014, p. 15). However, this limitation may also represent a source of strength as seen in the way that Glenda exploits the fluidity and unpredictability of the workplace to take up opportunities as they arise. The regularity with which she engaged in *follow up talk on bedside interactions* suggests that those were activities that she had planned to do with all students. In particular, Glenda's approach to *follow up talk on bedside interactions* seems planned in terms of intentionally allocating time and space to talk about what she

had observed in the patient room. The focal themes of the interactions are less planned in that they depended on the action that was taking place in the patient room. However, Glenda's attention on particular focal themes suggests she planned to address these themes at some point during the placement and took opportunities to do so as they arose. Similarly, while the overall interaction style of Glenda seems to be deliberate in that she finds out what students know, and then extends that knowledge, the particular patterns in each stage and with each student are contingent on how students participate.

As noted, the focal themes that Glenda pays attention to range from planned to contingent. The most planned seem to be those she focuses on at the end of extracts 4 and 5, where she attends to the skills she needs to assess. Here, the corridor is used as a retreat to ensure that students can not only undertake a blood pressure reading and pulse physically, but also understand the reasons why they need to carry out skills in particular ways. Each interaction with students differs depending on the medical condition of the patient, student performance of the skill, and student initiation of topics. However, Glenda seems to manage this wide range of possible topics by focusing on particular focal themes. In particular, she focuses on the process of nursing, that is, the need to notice patient signs and symptoms, interpret them, take action and reflect. Glenda can adapt this systematic approach to the particular context at hand, focusing on skills and practices that are appropriate for first year nursing students. Glenda's control of the topics in the extract 4 with Ryoko illustrate how she uses the situation at hand to focus on a medical condition but uses that not just to explore patient diagnosis and treatment but to demonstrate the process of making a clinical judgement. In contrast, in extract 5, Glenda's approach is contingent on the topics Soo-jin raises and 'grab[s] in passing' learning opportunities (Baynham 2006 p. 25). In this extract, the facilitator's contingency and the student's agency work together to produce a pedagogy that is more dynamic than observed in the encounter with Ryoko.

Soo-jin demonstrates more agency than Ryoko in that she initiates topics and builds on topics that Glenda introduces. However, Soo-jin's agency is also related

to a broader level of Glenda's planning (Gibbons 1999), in that Glenda puts in place the conditions for Soo-jin to take agency by directing students to participate in the *follow up talk on bedside interaction* activity. In comparison to the activity *checking in* discussed in Chapter 6, which required a high level of student agency, participation in *follow up talk* requires a lower level of student agency. In *checking in* activities, students had to ask the facilitator questions, as she visited wards on her daily rounds, in order to gain time spent with her in an *education frame*. Here, however, Glenda creates that frame for students. For EAL students in nursing and medicine who have been reported to find difficulties approaching facilitators with questions (Rogan et al. 2006) and initiating topics (Malau-Aduli's 2011; Woodward-Kron, Hamilton & Rischin 2007), planning activities that create opportunities to raise topics of concern can contribute to positive learning experiences for students.

The interactional patterns Glenda uses are also contingent on student responses, resulting in effective scaffolding of activities (van Lier 1996). The strategies are adapted to the students' stages of learning and their performance in English. In the interaction with Ryoko (extract 4), Glenda gives greater guidance, telling Ryoko more than she does Soo-jin. Glenda works in the students' ZPD by providing assistance only when students need it. She adjusts the amount of guidance she provides, taking into account what students know, whether they are able to use the words and phrases they need to complete the activity, and how they respond to her questions. The shift in interactional patterns from stage to stage, the switch between 'telling' and 'asking', illustrate Glenda's judgement as to when it is appropriate to elicit information and lead students to the correct answer; when it is appropriate to provide information that a student does not have or know, for example her explanations to Ryoko about Ventolin; and when it is appropriate to extend students' thinking as she did with Soo-jin in extract 5. In designing opportunities for corridor learning in this way, Glenda provides education that is appropriate to the student's stage of learning; is situated; and provides effective feedback, all of which are important for effective learning (Conn et al. 2012). Figure 9, below, illustrates Glenda's pedagogic approach and style on a continuum from most planned to contingent.

SPACE and TIME

- directing students to corridor
- allocating time for interaction

FOCAL THEMES

- core curriculum knowledge under assessment (vital signs)
- process of nursing: making clinical judgements
- patient conditions observed at the bedside (respiratory condition)
- student initiated topic (medication & low blood pressure)

PEDAGOGIC STYLES

Overall approach

- find out what students know before extending their knowledge
- slow pace of talk

Styles adjusted according to:

- students' capability: student responses; students' initiations

Figure 9: Planned and contingent pedagogic choices

In these encounters, Glenda's expert status with novice EAL students is demonstrated. Her use of space, and judicious choice of pedagogic styles help students become part of the community of practice. Whilst previous literature has identified some of the key pedagogic strategies that supervisors used with GP registrars (Morrison et al. 2014), and proposed models of learning, for example, the one minute preceptor model (Neher et al. 1992 in Molodysky 2007, p. 1044), few studies of learning and teaching in a health context have paid attention to language, and in particular strategies that can be useful for EAL students. In adjusting pedagogic styles, Glenda enables students to participate in activities that they may not be able to complete without her guidance. For example, her explicit guidance enables Ryoko to complete a linguistically challenging activity, that of

completing patient notes. Similarly, in the final stage of the encounter with Ryoko, Glenda relies heavily on initiation-response sequences to lead Ryoko to the correct answer. While these sequences have been criticised as limiting the opportunity for extended talk, they seem to be useful in this context, where Glenda is focusing on patient safety and where completing activities in a timely manner is of importance.

The corridor as a retreat provides opportunities for language socialisation. Whilst there may be few opportunities for talk in the patient room, the corridor can provide opportunities to extend the hands on learning, which began in the patient room. Whereas interactions in the patient room are mainly action focused, corridor talk is used to rethink what students have been doing or have seen in the patient room. In rethinking the previous event, language is part of a new activity, where the focus is student learning, and language is used to help students construct knowledge (Mercer 1995) related to the clinical events they experienced elsewhere.

As well as being important for student learning, corridor interactions also gave Glenda insights into what students could do, what they understood about the care they were giving, and the extent to which they could document that care, which then informed her assessment of students. Talking about a clinical event that happened in the patient room means students have to explain the underlying reasoning for actions undertaken in the patient room. Lu and Malthus (2012, p. 7) found that tutors expect students to 'articulate and explain the nursing decisions they make, and consider those who are unable or unwilling to do this to be unsafe practitioners'. Glenda provides expert guidance to support students to begin this process of making decisions and articulating them.

The *follow up talk* also gave Glenda extended time with students to monitor their English language, although she rarely commented explicitly on this to students, as the focus of these activities was clinical knowledge. When language was commented on, it was to name particular words or phrases that were used in the documentation, for example, 'drowsy'. As noted in the previous chapter, this finding is again similar to studies in healthcare supervision, which found that

hospital supervisors focused on clinical skills and content knowledge rather than communication (Elder et al. 2012; Woodward-Kron et al. 2012). Elder et al. (2012, p. 416) propose that the lack of comments on language skills may be because health professionals 'are ill equipped to …disentangle language issues from content knowledge and other health-specific aspects of communication'.

Students' perspectives

Students seemed to appreciate Glenda's approach to guide their thinking. Ryoko and Soo-jin both commented in interviews on the style of teaching of their facilitator. They felt that Glenda encouraged students to talk; was a good listener; asked students questions repeatedly until she was sure she had understood them; and finally, asked questions to prompt thinking. They also liked her slow manner of speaking and her clear explanations. Soo-jin sums up what she liked about the way in which Glenda guided her learning:

> … she was trying to teach us how to think critically and clinically … whenever we asked some questions, she didn't give us answer directly, she was asking us again 'how about something like that' 'good, good, it's close' … she was trying to make answer by ourself … I like it because, [if] she just … gave me the answer, I will just thinking ah that's it, however, if she was keep asking me again, again … that was fun for me … if nobody ask me I didn't really think about it and personally I didn't really have a skill to think about critically or clinically, but … that kind of question help me to … build up the critical thinking or clinical judgement …

Conclusion

This chapter confirms the important role the corridor plays as a learning space for students undertaking clinical placement. However, the analysis of the approach and strategies adopted by the facilitator in this chapter demonstrate an alternative view of corridor learning and teaching from that previously found (Molodysky 2007; Morrison et al. 2014; Pearce 2003). Whereas those studies focused on the ad hoc nature of corridor interactions, the approach Glenda adopts is intentional; focuses on what students already know and what they need to learn; and uses talk

to help scaffold students' thinking about clinical matters. The strategies Glenda adopts are similar to the demonstration, declaration and elicitation strategies found in Eggin's (2016) study. However, in that study, teaching often occurred while supervisors and students rushed along the corridor, and clinical 'tasks double[d] as teaching interactions' (Eggins 2016, p. 168). In contrast, Glenda uses the corridor as a retreat to stand still, where the primary frame of the activity is one of *education*. It is an approach to corridor learning that may be more suited to novice students, and particularly those for whom English is an additional language.

Glenda drew on a range of pedagogic strategies to guide students in actions, words and ideas, in order to develop their nursing knowledge, including the language of nursing. The overall pedagogic approach that Glenda adopted, which seemed useful for all students, and did not require a high sense of learner agency was to:

- provide access to a learning space – the corridor
- balance planned and contingent approaches to the choice of focal themes
- adjust pedagogic styles to guide thinking and language socialisation at a level appropriate to the students' ZPD
- engage in interactions that build a good relationship between facilitator and students.

However, as with other studies, (Eggins 2016; Rizan et al. 2014) there were many encounters across the three placements I observed where learning may have been limited. In my study, Glenda was the only facilitator who regularly organised learning interactions in the corridor, and who regularly used the kind of teaching strategies demonstrated here. The other facilitators observed often adopted a 'telling' approach, mainly giving information on medical conditions. As seen in this chapter, adopting a planned approach to using corridors as a retreat, following activities in the patient room, can create opportunities for students to engage in talk that may help them become socialised into the ways of thinking and talking like a nurse. The planned nature of the interactions may make it easier for students to initiate interactions, and the contingent pedagogic responses that are

appropriate to the student's ZPD can help them complete activities which they could not complete alone.

Chapter 9 - Nurses' Desk: decoding patient notes

The previous chapter discussed the pedagogic practices that one facilitator used when discussing with students activities that had occurred in the patient room. At times, the facilitator's feedback focused on helping to socialise students into one of the institutional discourses of nursing, that is completing charts. This chapter focuses on the extent to which facilitators helped students to learn further institutional discourses: the content and the language of patient notes, including handwritten progress notes; and a variety of hospital forms.

Hospital wards usually have a nurses' desk or station where patient records are kept, and where nurses spend time when not attending to patients (Hutton 2002). It is also where computers and telephones can be accessed, in order to research patient conditions and results. In my study, facilitators and students used the nurses' desk when looking at patient notes and records, and online resources. As Hobbs (2007) states, patient notes and charts play a vital role in managing information and in communicating amongst healthcare team members who care for patients, but do not necessarily meet face to face. This communication is essential to patient safety as, in Australia:

> Any one patient in a public hospital is likely to be seen by at least three teams of nurses over the course of 24 hours, two or more junior doctors and registrars, as well as the consultant specialist. Allied health professionals will have a role to play as well. No one person will carry the information about the changes in the patient's condition, the medication that has been prescribed and often changed, the test results which have been ordered, and the treatment regimes instituted by the medical staff (Garling 2008, p. 15).

Patient notes have traditionally been handwritten and legibility of notes is a recognised problem (Garling 2008). The introduction of electronic medical records has been designated a health priority in NSW from 2016-2026, but in the meantime, in 2016, only 35% of facilities were using electronic records (NSW Health 2016). In hospitals where I observed, the patient notes were mostly

handwritten. There are two sets of notes for each patient: the patient notes and the bedside charts. Patient notes include details about the patient's admission, medical treatments, and doctors' and nurses' progress notes. Doctors' progress notes contain the patient's current status, symptoms, medications and treatment plan and are updated regularly. They are a 'running log of the patient's care' (Hobbs 2007, p. 41). Similarly, nurses' notes are a record of activities carried out during their shift; they are also a place for nurses to record and report concerning signs (Hobbs 2007). In my research, patient notes were kept in ring-binder folders behind the nurses' desk. The bedside charts include vital sign recordings, and other charts monitoring the patient's condition and were kept by the patient's bed. These two sets of notes comprise the official record of patients' care and are legal documents (Levett-Jones and Bourgeois 2015).

Progress notes written by nurses and doctors are written in a particular style. Hobbs (2004, p. 1588) states that 'the chart [notes] is a complex technical account in a highly condensed form'. The notes contain many medical terms (Parks 2001) and abbreviations that are based on Latin terms (usually medical conditions); English terms (for example, SOB for 'short of breath'); and iconic symbols (for example, $\bar{c}$, a c with a line above, denoting 'with') (Hobbs 2004). They are also written with 'telegraphic syntax' (Hobbs 2004, p. 1587), omitting words, such as articles and auxiliary verbs. This style of writing contributes to notes being completed in an efficient way, which is essential in busy hospital environments. However, the condensed nature of the notes, the unfamiliar terminology and the handwriting can make the notes difficult for novices to read (Dickson 2013).

Several studies have investigated how novice students learn to produce correct documentation in clinical settings. A significant body of work examined how French speaking nurses in Canada, who were transitioning to work in English speaking hospitals, appropriated the genre of progress notes and nursing care plans used in the English-speaking workplaces (Parks 2000; Parks 2001; Parks & Maguire 1999). Hobbs (2004) focused on advanced medical students learning to write progress notes. Both medical students and nurses were found to learn over time, through situated processes of engaging with more experienced professionals

in both direct and indirect guidance. Examples of direct guidance were feedback on drafts, and direct corrections; indirect guidance occurred by participating in patient care, hearing talk of colleagues as they discussed care (Hobbs 2004), and reading notes written by other professionals (Hobbs 2004; Parks 2000; Parks & Maguire1999).

Guidance from nurses who were in official mentoring roles for the novice Francophone nurses in Park's (2000) study played a role in helping students learn to write nursing notes that were appropriate to the English-speaking hospital where they were working. Parks summarises three different types of help that were offered: linguistic, which pertained to vocabulary, and grammar; rhetorical, that is, indicating what to include in nursing notes and modelling specific phrases; and finally, information, which is related to disciplinary knowledge. Parks (2000) notes that this guidance was sometimes in terms of direct instruction (as compared to an approach where the instructor posed questions to focus students' attention on problematic areas). She argues that this type of direct modelling is in response to a workplace where efficiency is privileged, and where documentation has to be managed alongside a patient load and completed before the end of the shift. Direct guidance played a lesser role for the medical students in Hobbs (2004); however, some did receive feedback on drafts that they had written.

What seemed to play an even greater role than direct expert guidance in learning to write progress notes and care plans was what Parks calls 'covert' help (Parks 2001, p. 421), that is, by reading documents written by others. At the beginning of the shift the new nurses scanned patient charts (as did more experienced nurses) looking for relevant information and jotted down notes on a sheet of paper. As they worked with patients they added notes to the paper to use later in their nursing notes and care plans (Parks & Maguire 1999). As well as providing information about patients, reading the charts also give the new nurses appropriate language that they could use in their own notes and plans. The medical residents also referred to notes written by more experienced doctors to help them learn how to write medical notes (Hobbs 2004).

Both Hobbs (2004) and Parks (2001) argue that using the notes in this way is part of the process of learning to write in the genre of hospital documentation. Parks and Maguire (1999) refers to it 'as a kind of prewriting heuristic' (p161) and Hobbs (2004, p. 1601) states that the first step in appropriating the genre of medical progress notes is by first 'reading – or, more accurately, decoding - the notes of others'. Whilst reading these notes, students 'become familiar with the topics, order of presentation, and mode of reasoning that the notes contain' (Hobbs 2004, p. 1601) and 'and learn[s] to use, the terms, abbreviations, and discursive forms that constitute the specialty idiom' (p. 1603). Hobbs (2004) seems to be using the term 'decoding' to stress how unfamiliar patient notes are for novices and, in order to understand them, novices need to 'crack the code'. In particular, she notes that abbreviations 'render[s] medical records cryptic and incomprehensible to the uninitiated' (Hobbs 2004, p. 1586). The term decoding in this sense can be used interchangeably with reading but it highlights the highly specialised nature of patient notes.

The term decoding is also used in a large body of research related to learning to read in one's first language. Here the term decoding often refers to one aspect of reading, that is, the process of learning to read individual words (Garcia & Cain 2014), including how a student connects 'printed letter strings to words he or she knows in spoken form and thus discovers the meaning of written words' (Mullock 2008, p.5). This latter meaning of decoding is also relevant to my findings. However, in order to differentiate between the two meanings, I will use the term decoding as used by Hobbs (2014), that is to refer to the need for students to crack the code of a highly specialised discourse that is largely unfamiliar to the novice students in my study. I use this term interchangeably with reading. When referring to the more restricted meaning of decoding, that is, of understanding individual words, I use 'reading individual words'.

However, whilst acknowledging the importance of decoding notes, the above studies do not focus on how students come to decode those notes, nor what role supervisors play in that process. It seems to be assumed that reading notes is unproblematic, perhaps because in Hobb's (2004) case the medical residents were

advanced in their studies, and therefore may have had a level of familiarity with patient notes that enabled them to decode them. The studies of the Francophone nurses also do not discuss challenges nurses may have faced in initially reading the notes. Whilst English was not the first language of these students, they were also more advanced in their studies than were the first-year undergraduate students in my study and may have been more familiar with hospital documentation.

Little is known about the reading and writing practices of undergraduate EAL nursing students during clinical placement. It has been stated that nursing students need to complete documentation as part of the care they provide (Bosher 2010; Hussin 2002), but in a needs analysis of EAL nursing students, Bosher and Smalkowski (2002) found that producing correct documentation was one of the challenges for those students. EAL students in Dickson's study (2013) stated that reading notes was difficult and time consuming due to handwriting and vocabulary (both medical and non-medical). As electronic devices were not allowed on the ward, students in Dickson's (2013) study were unable to research unfamiliar terms. Students did say that facilitators helped them write documentation by providing them with appropriate and correct words. However, no information is provided as to whether the facilitator helped them understand and decode patient documentation. Dickson (2013) argues that an inability to read and interpret documents limited learning opportunities. She proposes that the best place to improve English language is in the clinical environment; students have very limited access to handwriting other than during clinical placements, and strategies students said they adopted to improve their English language, such as watching television, do not provide them with language that is appropriate for the clinical context. However, her study does not focus on how students can improve their English language performance in the clinical setting, nor what role facilitators might play in that learning.

Given the importance of engaging with patient notes to plan and manage patient care, and to develop appropriate writing skills, there is a need to investigate strategies facilitators use that may help students begin to make sense of handwritten, highly technical information written in condensed formats. This

chapter considers activities at the nurses' desk that helped students engage with documentation.

Activities at the nurses' desk

The setting

As mentioned previously, the two main activities that occurred at the desk were: *reading patient notes* and *researching information about patients*. The **nurses' desk** was a practical choice for these activities given that patient notes were usually kept at the desk. Furthermore, remaining at the desk meant the notes could easily be located by other staff if they needed them, which occurred regularly. The facilitator and students sat behind the desk *reading patient notes* or using the computer for research, and I sat alongside them, as illustrated in Figure 10 below.

Figure 10: The nurses' desk

However, sitting at the desk was also a way of making sure that the facilitator and student were visible on the ward to other nurses. As noted elsewhere, facilitators were not supposed to take students off the ward for any length of time. The need to remain visible seemed to outweigh the disadvantage of the background noise. On the eighth day, in Red Hospital, Glenda, the facilitator, looked at notes with a

student to help her make a time management plan. The time management plan referred to what students needed to do with/for a patient each shift and when they would do it. Glenda said 'I know it's noisy but we'll just stay here where everything is happening'. She said she did not want to take the student off the ward, where they could not be seen. 'Where everything is happening' refers to the activity going on at any one time at the nurses' desk, as illustrated in the extract below from my field notes:

> People are sitting at the computer and on the phone. There is a group of three people – maybe doctors looking at a computer screen together and talking. There are people looking at notes, people walking along behind the desk looking for notes. A hospital orderly walks along the front of the desk and a cleaner is cleaning between the desk and the door of the room opposite. It is a quiet noise, a purposeful noise- busy but not chaotic.

The desk was a central administrative point for incoming and outgoing telephone calls. In my study, it was also frequently used by doctors and allied health professionals when writing up notes, talking about patients or chatting socially with staff on the ward.

Remaining at the nurses' desk offered a further advantage for students. Mingxia mentioned at the end of clinical placement that it had been very useful for her that Glenda, the facilitator had organised access to the computer for them and sat next to them while they looked up resources. Mingxia said that she would not have felt comfortable asking nurses if she could use the computer, as she was not sure if it was appropriate for students to be sitting at the desk. In taking time out at the desk, Glenda was modelling to students that sitting and reading notes at the desk, and using the internet to research patient conditions were legitimate activities.

Gaining access to the activities

The activities *reading patient notes* and *researching information about patients* were carried out in both Green and Red Hospital but not in Blue Hospital. On two occasions, Mel, the facilitator in Blue Hospital, looked at patient notes in the *setting up the shift activity* but on the whole, she relied on the handover sheet to gather

patient information (see Chapter 10). Whilst the activities in Green and Red Hospitals both focused on *reading patient notes* and *researching information about patients*, the way students gained access to these activities at the **nurses' desk** was different in each hospital. In Green Hospital students moved from the corridor to the desk if they asked the facilitator, Kim, a question during a *checking in activity* on her daily rounds (see Chapter 6). On the fourth day, for example, Jing, a student, met the facilitator in the corridor during her daily rounds and Jing reminded her, 'you were going to go through the file of that patient with me- do you remember'. These activities are categorised as *unplanned*. In contrast in Red Hospital, most of the activities at the desk were initiated by the facilitator, Glenda, who approached students and directed them to the desk to read patient notes or research information on the online systems. The activities in Red Hospital are categorised as *planned* activities.

The goal of *unplanned* and *planned* activities differed. In Green Hospital, the goal was to find the answer to questions that students had asked; the questions were mostly requesting information about patients or medications. In Red Hospital, the goal was to understand how to use notes in order to plan care for a patient in a way that did not just rely on the information received in handover. Glenda's *planned* approach to the activities at the **nurses' desk** illustrates how Glenda was expecting students to research patient conditions, check the notes and provide individual patient care based on the patient's situation.

The two different approaches by facilitators led to different learning experiences for students. Table 20 (below) summarises the activities that occurred with each student at the nurses' desk in Red and Green Hospitals. As illustrated in Table 20, all students in Red Hospital spent time with Glenda *reading patient notes* and learning the systems to *research information about patients* at the **nurses' desk**. However, in Green Hospital, only three students spent time at the nurses' desk with Kim, the facilitator. Jing, in particular, spent more time with Kim than did other students.

Table 20: The nurses' desk: record of activities

GREEN HOSPITAL (Kim)				
	Planned activity		**Unplanned activity**	
Day 2	NONE		Hongyan	Patient notes and charts
Day 3			Jing	Patient notes
Day 4			Jing	Patient notes and charts
			Hongyan	Online resources
Day 7			Jing	Patient notes and charts
			Priya	Patient notes and charts
Day 9			Jing	Patient notes and charts
Day 10			Jing	Patient notes and charts
RED HOSPITAL (Glenda)				
	Planned activity		**Unplanned activity**	
Day 1	Soo-jin	Patient notes and charts	NONE	
	Emma	Patient notes and charts		
Day 2	Ravindra, Hua & Hannah-	Patient notes and charts	Ravindra	Looking up policies and procedures
	Mingxia	Online resources		
	Soo-jin	Online resources		
Day 3	Ravindra, Hua & Hannah	Patient notes and charts	Ryoko	Patient notes in response to Ryoko's question
Day 4	Ryoko, Soo-jin & Mingxia	Online resources Patient notes and charts (Mingxia)	NONE	
	Ravindra, Hua & Hannah	Online resources		
	Hua	Patient notes and charts		
	Ravindra	Patient notes and charts		
Day 7	Mingxia	Patient notes and charts		
Day 8	Ryoko Mingxia	Patient notes and charts		

This chapter focuses on the activity *reading patient notes.* It firstly discusses the focal themes and pedagogic strategies used by Kim, in Green Hospital, and then discusses the activity in Red Hospital.

Reading notes to learn about a patient's medical condition (Green Hospital)

As noted above, most activities at the nurses' desk in Green Hospital were unplanned**.** Jing and Hongyan were the only students who spent more than one session at the desk, and some students, for example Angie, had no time reading notes with Kim. Jing used the *checking in* activity, as Kim did her daily rounds, to find out about things she wanted to know (see Chapter 6). When Jing asked questions that required referral to patient notes, Kim took Jing to the nurses' desk to read the notes. On two occasions Jing wanted to know about the conditions of patients she had noticed who were very ill. On another occasion, she wanted to know what had happened to a dying patient that she had cared for the previous week.

In finding out the responses to Jing's questions, Kim adopted the role of expert practitioner and looked for the answer. She held the notes, flipped through the pages and searched for relevant information. She read aloud the notes but usually at a fast pace, and selected parts to focus on with Jing. Occasionally she asked Jing questions, often display questions to check Jing's knowledge, but predominantly she read out medical terms and then rephrased them. She also occasionally pointed out which notes to read and why. However, on the whole the focus was on finding out the patient's medical condition, and explaining it to Jing. As illustrated in Table 21 below, the three key focal themes were patient diagnosis and medical history; how to read notes; and the purpose of reading notes.

Table 21: Focal themes in reading notes in Green Hospital

Patient diagnosis and medical history	Medical terminology
	Abbreviations
	Non-technical terms
How to read notes	Which forms to read
	Decoding handwriting
Purpose of reading notes	Understanding the patient diagnosis

Setting and access

The extract below is an interaction with facilitator and student at the desk. Prior to this interaction, during a *checking in* activity, Jing (student) had noticed a doctor talking to a patient's family, and thought the family looked upset. Although Jing was not taking care of this particular patient, she was curious to know what was wrong with the patient, and had asked Kim (facilitator). Kim directed Jing to the nurses' desk where they sat next to each other (as illustrated below, Figure 11), with the notes on the desk. Both looked at the notes, but Kim turned the pages and chose what sections to read.

Figure 11: Reading notes at the desk

The following extract illustrates how the focus on reading notes at Green Hospital was predominantly on finding out about medical conditions. Hence the doctors' progress notes were most useful as they contained the medical details. However, as most of the information is new for the student, the facilitator explains it to the student. Furthermore, the knowledge of the patient that Jing brings to the interaction is limited to something she observed. She has not been involved in the

patient care and therefore has not heard talk about his condition, which may have helped her understand the notes (Hobbs 2004).

Extract 6: Reading notes to learn about a patient's medical condition

Day 4: Green Hospital: nurses' desk Jing (student) Kim (facilitator) Researcher		
1	Kim:	so THIS is actually from the emergency department … [*looking at in patient's file*]
2	Jing:	oh?
3	Kim	on the 17th he came in with nausea dizziness xxxx and a background of xxx syndrome … I find the emergency notes really helpful because these are all written by the doctors
4	Jing:	oh?
5	Kim:	okay so these are from emergency … these are the doctor's progress notes in emergency they type up their notes a lot of the time um and so I find these really helpful because it gives you the history, medication, allergies, history presented on the 7th history of xxxx um (2) …this what they think impression
6	Jing:	mm
7	Kim:	that's what they think is wrong (1)
8	Jing:	I like this because it's not handwriting//
9	Kim:	//yes it's not handwriting [*both Kim and Jing are laughing*] you can read it (4) yes this is the plan this is a long plan see it starts from here
10	Jing:	ECG – I know ECG sinus sinus [Jing mispronounced this word with a short i] what's that [*looking at the word tachycardia and not knowing how to pronounce it*]
11	Kim:	tachycardia, tachycardia yes, you know what tachycardia is.
12	Jing:	I have seen that
13	Kim:	yes? what's tachycardia (3) what's bradycardia. (3)
14	Jing:	no I I er I'm very not
15	Kim:	it's a fast heart rate
16	Jing:	oh okay (4) OH I know…

17		[*Kim continues to look through the notes*]
18	Kim:	he's got ongoing post xxx abdominal pain (1) bowels open, ulceration and colitis he's got inflammation inside his xxxx … they're thinking all sorts of things okay question mark ischaemic bowel disease which is where your stomach your bowel is er not getting enough blood you know you've got the vasculitis
19	Jing:	yes.
20	Kim:	which is? (1) inflammation of your vessels and it's a general word you can have vasculitis in different parts of your body but he's got it like quite all over because its affecting his lungs, his kidneys his heart and his stomach area//
21	Jing:	//so it's spread everywhere
22	Kim:	so yes so xxxx some ischaemic bowel disease … so he's very interesting and he has a lot of problems when you do your research you can see whether people can be cured of that
23	Jing	oh yeah sure//
24	Kim	//or not …
25	Jing	oh I'm waiting for the obs …

Although Jing initiates the question about the patient's medical condition and closes the interaction by stating that she needs to go and measure a patient's vital signs (turn 25), Kim controls the majority of the talk. She holds the notes, turns the pages, and skims through the notes, looking for relevant information. At times she read aloud, but quietly as if to herself, and at times she read aloud to Jing. She points out which notes to read (turns 1 and 5) and why they are useful. In focusing on the patient's medical condition, Kim reads the doctors' progress notes rather than nurses' progress notes. She also explains the language of the notes to Jing, telling her that 'impression' is what doctors think is wrong with the patient. Whereas Kim talks about the content of the notes, Jing points out that she likes them because they are not handwritten, suggesting she has difficulties with reading handwriting. However, in this interaction the handwriting is not a problem for Jing, who only attempts to read in turn 10. On the whole, Kim offers direct guidance to Jing, similar to the nurses in Parks' (2000) study.

Kim mainly uses a 'telling' strategy reading out the medical condition of the patient and explaining what that is; examples are seen in turns 18 and 19. On two occasions, Kim asks Jing display questions (turns 11 and 20). In asking Jing what 'tachycardia' (a fast heart rate) means, Kim seems to be assuming that Jing will know this term, and Jing probably has come across the term during her studies. However, Jing cannot recall what it means, and although Kim tries to help her by prompting her with the term that means the opposite, bradycardia (a slow heart rate), Jing does not know. In turn 20, Kim asks Jing what vasculitis means but here leaves only a one second pause, perhaps assuming Jing will not know this term. The focus is on explaining what problems the patient has rather than finding out what Jing knows. Kim's comment in turn 22, that the patient is very interesting, sums up what the goal of this activity seems to be; to find out about unusual medical conditions, with the explanation of notes as secondary focus. The attention paid to interesting cases is similar to Kim's approach in *the debrief* that focused on asking students what interesting or new things they had experienced during the day (discussed in Chapter 10).

This extract also illustrates one of the challenges for students in reading notes, that is the large amount of unfamiliar medical terminology. Words with which Jing was probably not familiar in this extract include: xxx syndrome; tachycardia; bradycardia; ulceration; colitis; ischaemic bowel disease; and vasculitis. This extract is only approximately one minute from a seven-minute interaction. The rest of the interaction also consisted of many medical terms.

The purpose for reading notes in Jing's case was one of satisfying her curiosity and extending her knowledge about medical conditions. As well as finding out about the patient's condition, however, Jing did learn something about reading notes; that reading emergency notes or doctors progress notes will provide her with information about the patient's medical condition, and other relevant medical history. She also learned that the progress notes may be typewritten which may overcome a difficulty with handwriting. However, she has not learned how using this information might be relevant to her daily work as a nurse. There was only one occasion where I saw Kim point this out to a student, Priya. As Kim completed

her daily rounds, she noticed Jing and Priya in the corridor. They were practising giving a handover, in preparation for doing handover with their buddy RNs that afternoon. Kim asked Priya how she felt about doing the handover and when Priya told her she was nervous, Kim took her to the desk to look at the patient's notes, in order to gather information about Priya's patient. Whilst reading the notes, Kim told Priya 'when you look after a patient you need to know what's wrong with them- you can't just look after them'. Kim then went through the notes with Priya, reading aloud as she did with Jing in the extract above and at the end of the session concluded it by saying:

> So when you've got a patient sit down and read the notes … so when you've got nothing to do like you've done your showers, you've done your obs, checked if anyone needs any help, you've done the beds, read the notes. It's very important you get in the habit … if I was coming on the afternoon shift … I would come and read the notes not all of them but I would read … the emergency notes because that will tell you what they came in with and it tells you what their history is PMH is past medical history and then I'd go to the doctor's notes at the very beginning and I'd read what they think is wrong see xxx impression IMP is impression that means they're going to write down what their impression is what they think is wrong and they'll give you a plan okay … and then I would go to today and I'd read what's happened …

Here Kim points out the nurse's responsibility in reading notes every day – once patient care has been carried out. This interaction occurred on the seventh day but it was the only time I explicitly heard Kim talking about the need to read notes. Kim may have been assuming that students already knew they should be doing this. There were, however, no activities that required students to read notes, or demonstrate they were planning care, or finding out about their patients' medical diagnoses. Although some students were writing progress notes and giving handovers with their nursing buddies and may have had had access to patient notes with them, it was not clear whether all students had access to this kind of support from their buddy nurse.

Furthermore, Kim's comment above raises one of the tensions for students: namely, whether to help other RNs by completing a range of clinical tasks for a number of patients (for example, taking numerous blood pressures), or whether to focus on one patient. Furthermore, there seemed to be a lack of clarity about what exactly was meant by focusing on one patient. Here, Kim seems to be suggesting to Priya that she should attend to clinical tasks first, as well as seeing if anybody, including nurses, need help before reading notes. Completing clinical tasks seems to be prioritised over reading notes.

Reading notes to plan a patient's care (Red Hospital)

Whereas Kim concentrated mostly on the doctors' progress notes, Glenda took a broader approach to reading notes. As noted above, previous research has focused on writing nurses' and doctors' progress notes and nursing care plans. However, Glenda's interactions with students demonstrated that there is a large range of forms with which students need to be familiar, and that understanding these forms can be challenging for students, particularly EAL students. Some of the documents I noted in my study that Glenda referred to are illustrated in Table 22.

Table 22: Hospital forms referred to in Red Hospital

Admission form	Theatre/surgery chart
Pre-operative check list	Patient consent form
Falls chart (assessing risk of patient falling)	Vital signs chart
Pressure sore chart	Medication chart
Nurses' progress notes	Doctors' progress notes
Care plan	Dietitian notes
Social worker notes	Pathology results

Most of the nurses' desk interactions in Red Hospital were *planned* and initiated by the facilitator. The goal of the *reading patient notes* activity was to go through the notes about a patient – but rather than seeking out information about the medical condition, the goal was to gather information that was relevant to planning care. Glenda expected students to take one patient a day, and to plan their care not just by reading the handover sheet but by referring to patient notes. The interactions

with Glenda provided an opportunity for students to find out about their patient, to ask questions and learn about medical conditions, and the health care system. Unlike Kim, who emphasised the medical conditions, Glenda framed the *reading notes* activity within a broader framework of patient care. She went through not just the medical progress notes, but also notes related to the patient's admission, the nursing notes, the nursing care plans and a range of charts. This broader focus meant there was also a range of non-technical vocabulary that was new for students, as well as information about the healthcare system. These focal themes are summarised in Table 23 below.

Table 23: Focal themes in reading notes in Red Hospital

Patient care	**Patient diagnosis and medical history**	Medical terminology
		Abbreviations
		Non-technical terms
	Patient situation (including psychosocial)	Healthcare system
		Non-technical vocabulary
How to read notes	Which forms to read	
	Decoding handwriting	
Purpose of reading notes	Making a daily care plan	
	Understanding the patient diagnosis	
	Professional responsibility	
How to write notes	Legal documentation	

Whereas Kim predominantly adopted a role of clinical expert finding out about medical conditions, Glenda predominantly adopted a role of expert teacher showing students the purpose of reading notes, and how to read them. Rather than reading aloud to students, the strategy Glenda adopted was more of a 'reading alongside' strategy. At times, when the information was medically dense, she read aloud and explained, but she also gave students the opportunity to read themselves by physically passing the notes over to them and asking them to read to her. The extract below illustrates these focal themes and strategies.

Setting and access

Glenda had met Ryoko in the corridor, and directed her to the nurses' desk to initially find out information about a patient that Ryoko was caring for, and also to 'go through the notes' with Ryoko. This was in the early evening and Glenda split this session into two 30 minute sessions. At one point, Glenda and Ryoko moved from the nurses' desk to a small patient lounge, perhaps to find a space that offered more aural privacy – however, a nurse came in search of the notes, and had been looking for them for some time, highlighting the advantages of staying at the desk.

Extract 7: Reading notes to plan a patient's care

Day 8: Red Hospital: nurses' desk and small lounge Ryoko (student) Glenda (facilitator) Researcher		
1	Glenda	... this is the admission page and it's good to read this because it gives you an idea of where they live … he's married so you know there's going to be some sort of support for him when he leaves the hospital and there she is living at the same house … it's good to know those things because then you have an understanding of what it's going to be like for him to leave here …. we'll just read this first okay so (3 secs) can you read the notes
2	Ryoko	that one
3	Glenda	here
4	Ryoko:	oesopho oessopho oespophogeal [*trying to pronounce the word*]
5	Glenda:	that's pretty good … yes so oespophogeal
6	Ryoko:	oesophageal so you don't pronounce that one [*pointing to the first o*]
7	Glenda:	no yes the o is SORT of silent um and the g is soft oesphogeal [*Ryoko repeats the word*]
8	Glenda:	And then that's squamous (1) cell carcinoma yes (7)
9	Ryoko:	can you say that again sorry
10	Glenda:	[*Glenda spells the words and Ryoko repeats back*] squamous s q u ((s q u)) a m ((a m)) o u s ((o u s)) cell in other words c e l l carcinoma c a r ((c a r)) c i n ((c i n)) o m a ((o m a)) and that's a cancer so squamous cell cancer … do you want to have a read and

		you can stop me if you feel you want me to explain [*Glenda passes the notes back to Ryoko*]
11		[*Ryoko reads quietly as if reading aloud to herself. When she cannot understand the handwriting or terminology she asks Glenda. Sometimes Glenda continues to read and they swap the notes back and forth]*
12	Glenda	… now if you've got … progress notes further in do you mind if I take this [*Glenda takes the notes and flips through the pages*]… we'll start with today's … so these were his night notes
13	Ryoko	… patient appeared and leeping on ward leeping?
14	Glenda	yes
15	Ryoko	what does leeping mean.
16		[*Glenda mimes being asleep*] sleeping
17	Ryoko:	oh sleeping I thought leeping sleeping on the ward
18	Glenda:	you're not supposed to say appeared … why they say appeared rather than sleeping is because if you don't say appeared and they turn around and say I haven't slept a wink but
19	Ryoko:	they're just looking
20	Glenda:	yes so whether you just say eyes are closed and breathing heavily, you say what you … noticed but people still put appeared even though they say you shouldn't …
21	Glenda:	… [*Ryoko hesitates when trying to read a phrase*] E N T so its ear nose and throat
22	Ryoko:	(2) ENT (4) E N T ear nose and ear nose and [*Ryoko write this down as she is talking*
23	Glenda:	throat
24	Ryoko:	throat yes
25	Glenda	(2) so ears nose and throat
26	Ryoko	ears nose//
27	Glenda	//and throat so nurses ((nurses)) so ENT nurse have attempted
28	Ryoko	(2) to unblock unblock?
29	Glenda	unblock
30	Ryoko:	unblock the valves (3) valves without success
31	Glenda	mm they couldn't unblock the nasal gastric tube

32		[*This reading notes activity continues for a total of 30 minutes*]
33	Glenda	… it's only if you start doing this that you're going to get comfortable with the writing he has horrible writing okay ... and unfortunately that doctor's information is so important that's the unfortunate thing about it…

After a tea break, Glenda and Ryoko meet again for another 30-minute session with notes

34	Glenda:	so we've got the idea about um reading the progress notes … the important thing also with progress notes is that you've got to have the label on both sides because if the label is not there you don't know who they're actually written about okay so if … for example there was no label there you could not write here you draw a line and start a new page with a label … … this here is the pre op check list so pre op check list …. have you done this? [*Ryoko says no and Glenda explains it*] … so are you comfortable with the care plan how the daily care plan (12)
35	Glenda:	do you look at these each day
36	Ryoko:	no
37	Glenda	[*flipping pages in the notes*] … so I'm asking you to look at these it should be at the front there it is okay [*Glenda reads aloud the care plan*] so … he needs assistance with his activities of daily living and showers … so very important when I'm asking you to read their notes so tomorrow I'd be asking that you read the progress notes from the night staff tonight and the morning staff if you're going to follow this patient okay and also look at his care plan on his bed charts so that you can make your time management plan
38	Ryoko	who's going to write down the … management the nurse?...
39	Glenda	they do but when you're taking care of the patient I'm wanting you to do it … so that's why we're trying to get you familiar with reading the notes and reading the handwriting

This extract illustrates how Glenda uses notes to focus on holistic patient care. In this interaction, Glenda pointed out the admission form, the doctors' and nurses'

progress notes; the consent form; the pre-operative checklist; and the daily care plans. With other students, she also went through two forms that assessed a patient's risk of falls and pressure sores. As Glenda explained to another student; 'as an RN … you're wanting to get the picture of your whole patient - it's important to read the bedside notes, the notes and power chart' (where patient results were accessed).

This attention to holistic care was also reflected in the order in which Glenda read forms with students. She suggested they began with the admission form. Hence her focus for the nurses' role was not only on knowing the patient's medical condition but also the support they would have when they were discharged. Reading the admission form also opened up opportunities for students to learn about the healthcare system. Hua asked Glenda if patients who were unable to return home immediately on discharge would go to a nursing home. Glenda explained the difference between rehabilitation and nursing home care. Mingxia, in reading the patient admission form, followed up with questions about private health care – a system with which she was unfamiliar.

Whereas Kim in the previous extract mainly read aloud the notes, Glenda often asked students to read (turns 1 and 10). This strategy meant that she could see what students were capable of reading by themselves, and step in when they needed help. The help required could be because students were unfamiliar with a medical term or abbreviation, for example ENT (turn 21), or the pronunciation of a term they have seen, for example oesophageal (turn 4). Students also needed help with some of the 'telegraphic syntax' (Hobbs 2004, p. 1587) of the forms; for example, in this interaction, Ryoko asked Glenda, 'Radio therapy day 2 does that mean second day'. Glenda confirmed it meant 'he had had two days of radiotherapy'. When students were in control of reading the notes, the reading process was slowed down as the students set the pace. They seemed to regularly ask questions about the meaning of medical and non- medical terms, and asked how to spell or pronounce them, as Ryoko illustrates in this extract. Ryoko's confirmation strategies, as well as Glenda looking over Ryoko's shoulder to observe as she was writing down new terms, resulted in repeated explanations

until students were clear (turns 21-27). Other strategies students used were to repeat back the spelling of words to confirm they had understood correctly and to give them time to write down the terms (turn 10).

Although Glenda asked students to read the notes, she at times also read them aloud, particularly when there was a large amount of medical terminology. Some of the terms that were new for Ryoko in this interaction were: prostate cancer, dysphagia, GORD (gastro oesophageal reflux disease); endocrine; and nasal feeds. Glenda also often used a 'reading alongside' strategy, where both Glenda and the student read together in a to-and-fro sequence (turns 27-31). Glenda leaves silences for Ryoko to take up the reading aloud (turn 28), confirms her attempts at decoding words (turn 29) and rephrases what Ryoko has read, to clarify what the notes meant (turn 31). Glenda's approach to reading with students was in Ryoko's words like 'reading with my Mum'.

Handwriting presented a significant challenge for students and facilitator. At times students could not read individual words even though they were terms that were familiar to them. Hua, for example, hesitated and then asked for help with a term she could not read. When Glenda told her it was vital signs, Hua laughed as this was a term she knew well. As pointed out by Glenda, the writing was 'horrible' (turn 33) and it is only by reading it that students will get comfortable with it. However, students often needed Glenda to help them read individual words due to the illegibility of the writing.

Apart from medical terminology and handwriting, students hesitated over terms that were specific to the hospital setting and were unfamiliar to students. These terms were often in the nursing notes. At one point in this interaction (not shown in the transcript above) Ryoko puzzled over the term 'can have gate leave' (as did other EAL students I observed) and Glenda explained it meant that the patient was allowed to leave the hospital for a specified amount of time. Abbreviations, for example ATOR (at time of report) were also difficult for students.

Apart from learning something about the social history of their patient, and medical and non-medical terminology, students also learned in this activity some information about how to write progress notes themselves, including making sure they complied with the legalities. As notes are legal documents, each page needs a patient ID sticker and Glenda explains to students what to do if no sticker is present. As noted previously, progress notes are written in particular ways and one of those is in terms of writing about what nurses have observed. Hobbs (2007) notes that when doctors have witnessed something themselves, then the notes are written as facts. When they are writing about something that somebody told them, the passive voice is used. Here, Glenda adds to that list related to legalities, that nurses should only write what was observed, by explaining that nurses cannot write that the patient was sleeping, and that they should not use the words 'appeared to be sleeping' as were used in the notes. Levett-Jones and Bourgeois (2015) also advise that students avoid the word 'appears' as students should record what they see rather than what they think they have observed. Here Glenda suggests 'eyes closed and breathing heavily'. The facilitator here plays a role in critiquing the notes students read during clinical placement, pointing out when they do not comply with legal status.

Finally, Glenda related the activity of reading notes to students' daily practice, explicitly stating when, how and why they should be reading notes. Although I had been aware throughout the placement that Glenda had been asking students to look after a patient each day and to read their notes and do a time management plan for each patient, it became clear that not all students had understood Glenda's expectations. Glenda used the *reading patient notes* activity to check whether students were planning care and to reinforce what she wanted them to do. In this extract from the eighth day of placement, Glenda found out that Ryoko had not been reading the nursing care plans (turns 35 and 36), went through the care plan with Ryoko, which states what needed to be done for the patient during that shift and explicitly told Ryoko that she expected her to read the notes and then make a time management plan for the patients. Part of the confusion for students seemed to arise because they were relying on the handover sheet and nurses' instructions to make their time management plan. The handover sheet

had brief typed information about patients including diagnoses, background medical information and often points about care for the shift. When I interviewed Hua about her clinical placement, she told me that she planned care for patient using the handover sheet and that she looked after 10 patients per day with two other nurses. She said she wrote the time management plan for these patients and in order to do that she used the handover sheet. She only went back and looked at patient notes if something special was mentioned in handover. However, Glenda expected students to look after one patient each day and for Glenda that meant reading the patient notes and bedside notes of each patient – not just relying on the handover sheet. When I said to Hua this is what I thought Glenda expected them to do she laughed and said 'I never heard this before'.

This expectation was similar to what Kim told Priya in Green Hospital, although Kim did not make this clear to all students. In Blue Hospital, students relied on the handover sheet to pass on information to Mel and other students about patients and they did not consistently look at patient notes with the facilitator (see Chapter 10). Thus, there seemed to be different expectations as to students' depth of knowledge about patients and what their role was in managing care in each hospital.

One of the tensions students face during clinical placement is managing the expectations of their facilitator and their buddy RNs. Hua focused more on nurses' expectations than the facilitator's. She distinguished between looking at notes for the patient in order to write her progress notes (which she did with the RN) and looking at notes to plan her time management plan (which she tended not to do). She said whilst both facilitator and nurse are important 'in this situation we are put in the ward and the nurse expect us to do those jobs if we don't do that they will do that but yes I think it's kind of we need to get used to the routine jobs'. The routine jobs for Hua included carrying out vital signs, and other basic care for 10 patients.

A guided approach to using and reading patient notes

The importance of accurate hospital documentation is clearly recognised in the professional standards for RNs in Australia (NMBA 2016), which stipulate that a nurse 'maintains accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations' (standard 1.6). The legality and importance of documentation is also stressed in undergraduate nursing texts (e.g. Levett-Jones & Bourgois 2015). However, the emphasis in these areas is often on the production of accurate documentation, rather than reading and using documentation in daily practice. As noted previously, existing studies have focused on how nursing and medical students learn to write progress notes and care plans, and found that reading documents written by other more experienced health professionals played a vital role in learning to write notes (Hobbs 2004; Parks & Maguire 1999). My study extends previous research on learning to write in two ways; firstly, it considers how facilitators explicitly guide students in the purpose and function of reading notes in everyday planning of patient care; and, secondly, it illustrates the challenges students face when reading documentation, and strategies facilitators use to guide students in meeting these challenges.

A recent report in the media highlighted how vital it is for nurses to read patient notes before administering care (Opie 2016). In the case reported, a man died when an oxygen line was incorrectly fitted. The nurses caring for him had not checked the patient notes and had missed a request from doctors that the patient not be connected to oxygen. At the inquest, the RN caring for the patient said that he had not had time to read the progress notes, and that nurses often relied on verbal handover for information about patients. The coroner disputed this claim and asked 'how on earth can a system like this be relied on in a major tertiary hospital' (Opie 2016). What is at issue is the amount of information nurses need to look after patients. Whilst the written document that accompanies verbal handover lists information about the patient's medical condition, background medical problems and current treatment (see Chapter 10 for further discussion on verbal handovers), it is limited compared to information that is documented in the patient notes. However, as the RN in the case reported in the media noted, when

the wards are busy, nurses may rely on verbal handover (and the accompanying typewritten sheet) to carry out patient care.

The data presented in this chapter show that there were disparate expectations between facilitators and students about the extent to which students should, during this clinical placement, read patient notes to plan care. As noted above, some students, like the nurses in the media case above, relied on the handover sheet rather than notes. Likewise, facilitators approached the reading of patient notes in different ways. Glenda was the only facilitator who systematically and explicitly showed all students under her supervision how to read notes, and also followed up on her expectation that they read patient notes in order to plan their patient care. Kim at Green Hospital, also expected students to read notes for their patients, as illustrated by her comment to Priya above but did not make this explicit to all students. In Blue Hospital, Mel, the facilitator, did not spend time reading notes with students. It was also not clear to what extent she expected students to read notes. Instead, students focused on practising verbal handover, relying on the information sheet from the handover, and information they had gathered throughout the day (see Chapter 10 for a discussion of handover).

Despite Glenda's instructions to read patient notes, as illustrated in extract 7, most of the students I observed did not regularly read the notes. Instead, students were sometimes completing clinical tasks for a number of patients and relying on the handover sheet, as well as RNs' instructions to gather information about patients. There are several reasons why students may not have understood, or chosen not to follow Glenda's expectations. Firstly, there is an overwhelming amount of information during clinical placement that students need to absorb, and most of this information is presented orally. Glenda stated her expectation verbally, and unlike the list of clinical skills presented on the clinical assessment form that students ticked off as they completed them, 'reading notes' was not presented as a 'skill' to achieve. As with the existing research on documentation, the focus was on the production of documents. Under the category of clinical communication and documentation, the skill to be developed was reporting care and writing progress notes and recording vital signs and fluid intake and output. There were several

places on the assessment form where reading notes was implied, for example 'identify various sources of patient data', and 'start to plan activities and organise time'. However, there was no clear stipulation that students were to plan care for a patient and what exactly that entailed.

Secondly, students may not always understand or fulfil the expectations of their facilitator as, during clinical placement, they receive instructions from multiple expert others, including their buddy RN (who, as mentioned earlier, may be a different RN each day) as well as from their facilitator. At times, these instructions may not align – for example students may be working on a ward where they are asked to take complete tasks within their scope of practice for a number of patients – as was Hua's experience described above. Levett-Jones and Bourgeois (2015, p. 22) note in their 'essential guide for nursing students' to clinical placement that students can sometimes 'try too hard to fit in … [and in doing so can] sometimes sacrifice their 'student status' to become one of the 'workers''. As a result, students can fill their 'days with a series of disjointed nursing tasks (making beds, taking vital signs, bathing patients) rather than developing their ability to nurse holistically across a range of areas'. Students need to be able to balance the 'doing' and the 'reading about patients' of clinical work. The 'doing' of the clinical tasks provides valuable hands on experience which they can gain by taking guidance and instructions from the RN. The 'reading about patients' helps students understand and develop the process of planning care by reading patient notes. However, for many students, particularly EAL students, reading notes may be time consuming and students may need more guidance than their buddy RN can provide. Glenda's *planned* approach to reading notes provided students with support in this vital area.

The data presented here show the challenges of reading notes, particularly for EAL students. One of the challenges is the local knowledge contained in the notes, which ranges from the Australian healthcare system, the internal structures of the hospital (for example, how patients are admitted), and social and cultural knowledge about patients' home lives (for example, relationships, living arrangements, vicinity to hospital and follow up treatment). A further challenge is

the unfamiliar terminology with which students are faced when reading notes. Hsu (2013) notes that medical students have to deal with not only medical terminology but also sub-technical terminology, which refers to common words that occur with specific meanings in different disciplines, for example syndrome. Likewise, they need to contend with lay-technical terms (Hsu 2013), for example, immune. As noted previously, students in my study also had to read words and phrases in the nursing notes that are comprised of lay terms but have specific meanings in the clinical environment, for example, 'gate leave'. EAL students may also struggle with general vocabulary that would not be problematic for fluent speakers of English, for example, 'flight of stairs'. Two other challenges were the large amount of information contained in patient notes and the difficulty of reading handwriting. Given these challenges, in my study, reading notes alone seemed to be an activity that was beyond most students' ZPD. It was only with the guidance of the facilitator that they were, as Ravindra said, able to 'make sense' of them.

The two main strategies adopted by facilitators were telling students what to read and why, by pointing out the purpose of the forms and notes, and selecting which parts to read. Secondly, they helped students read individual words on the page by reading aloud or reading alongside students. The read aloud as demonstrated mostly by Kim, was a more time efficient way of finding answers to specific questions, and of pointing out key words. However, students tended to ask fewer questions when the facilitator read aloud. When the facilitator was in charge of reading, it was also difficult to judge the extent to which the student could read the notes themselves. In contrast, reading alongside, as mostly demonstrated by Glenda, took more time, and it may not always be possible for facilitators to find time on the ward to read with students. However, in reading alongside, Glenda was able to judge how much of the notes students could read independently, and to provide support where needed, working in their ZPD.

In a review of the development of reading skills in in language teaching for specific purposes, Grabe and Stoller (2013) found there was a paucity of contemporary research on reading-skills development for students who were learning English for specific purposes. It is outside the scope of this thesis to investigate literature on

reading practices for first and second language learners. However, it is worth noting that the reading research that has been conducted with second language speakers which found that reading aloud may not be an effective way of learning to read (Liu 2013; Mullock 2008), is not necessarily applicable to the type of reading that students are engaging in when reading patient notes. The purpose of reading aloud when learning to read in one's first language is to decode the letters to sounds (Mullock 2008), and it enables the teacher to monitor students' progress with decoding. The argument that reading aloud may not be effective for second language speakers is based on the proposal that learners can draw on their reading skills from their first language, and employ a 'top down' approach to reading which enables them to read for meaning, and that readers do not have to understand every word to understand the meaning- hence decoding is not necessary. However, as noted above, the truncated style of progress notes means that there are not many words students can omit and still understand the meaning. Decoding seemed to be necessary for the students in my study to decipher the handwriting and abbreviations and understand the content. Research that has been carried out on reading in a second language (see Grabe & Stoller 2013) also tends to refer to longer texts, for example academic texts, that have an overall rhetorical structure that can help students work out meaning. Patient notes are not structured in this way. Interestingly, at one point during reading notes, Hua commented that the notes written by the social worker were easier to read 'because they were like a story'.

Patient notes are highly discipline specific to medicine, nursing and allied health. Grabe (2009) and Grabe and Stoller (2013) argue that if students are to succeed in learning to read discipline specific material in a second language they need to develop a large body of disciplinary terms that they recognise; and to recognise the rhetorical structure of texts. My study illustrates some ways in which facilitators can guide students to read patient notes. The strategies used by facilitators, in particular reading alongside may help students develop terms that are specific to the wards they are working on, as well as more general non- technical phrases. Their explanations of the various forms and the suggestions about the order in

which to read them can help students understand the overall patterns of notes and charts that are in patients' files.

However, it may not be sufficient for students to only be exposed to reading handwritten patient notes during clinical placements. Reading notes is a vital work practice that students need to develop throughout their degree. Whilst data presented here show that facilitators can provide important scaffolding in reading notes during clinical placements, there need to be further opportunities to develop students' abilities in reading patient notes prior to clinical placements. Although the students I observed during clinical placements, had seen charts as part of their university studies, and had learned about writing nursing progress notes, many of them needed more explicit guidance in reading doctors', nurses' and allied health practitioners' notes, as well as the large number of forms and charts in patient notes. As discussed in Chapter 2**,** programmes that provide support to EAL students prior to clinical placement have focused on developing students' oral communication skills for the clinical environment and their academic writing skills. There is however clearly a need for programmes that help students understand how to read notes.

Conclusion

This chapter demonstrates how the facilitator's overall approach can determine whether EAL students gain access to opportunities to read patient notes under guidance. It also shows that EAL students can benefit from this guidance. The pedagogic strategies discussed in this chapter, that is a planned approach to reading notes, and both reading aloud and reading alongside strategies can help EAL students to be socialised into this particular genre of writing. Given the importance of notes in patient safety and the multiple challenges that reading documents raises, a more structured and scaffolded approach to nursing documentation would be warranted, beginning in university before clinical placement and then in the placement itself.

The findings in this chapter also raise the issue of the purposes of reading notes in the patient care process, and the RNs role in ensuring that they are familiar with all

documents related to patient care. As in the case reported in the media (Opie 2016), my study also indicates that some students may spend their clinical placement relying on the verbal and written handover sheet to plan and conduct patient care, rather than referring to nurses' and doctors' progress notes. Glenda, at Red Hospital, was the only facilitator who consistently directed students to patient notes and reiterated that it was the students' responsibility to read the notes. Students and facilitators would benefit from clear guidelines about expectations of first year students in which documents to use, and when and how to use them, to plan patient care. These expectations would also need to be clearly articulated to buddy RNs.

This chapter has also highlighted some of the potential challenges for facilitators in making assessments of students' English language proficiency, and the extent to which facilitators should take into account students' ability to read and write progress notes and forms. Glenda was concerned about Ryoko's level of English language during the reading notes session. However, due to the lack of clarity in the clinical assessment form regarding what was expected of first year students in terms of reading and writing notes, she was not confident in making this assessment. Whilst there have been some initiatives to help facilitators assess students spoken English language during clinical placement (San Miguel & Rogan 2015), there is clearly a need for further research into the assessment of reading and writing practices in the clinical setting.

Chapter 10 - Ad hoc spaces: end-of-day debriefing

The previous chapters have focused on how facilitators help students to gain access to learning opportunities as they went about their work in the hospital wards; in the corridor, the patient room and the nurse's desk. This chapter focuses on how facilitators enabled or constrained student learning during the *end-of day-debrief*, which was one of the regular activities held in spaces away from the ward, and was the most prearranged activity of the placements I observed.

In nursing, the *end-of-day debrief*, (Davies 1995; Horsfall 1990) or 'post clinical conference' (Hsu 2007; Rossignol 2000; Vezeau 2016; Wink 1995) is a common practice, where students and facilitators meet at the end of clinical placement shifts, in order to talk about the events of the day. A further type of debrief in healthcare situation is the *post-simulation debrief*, which refers to sessions following simulated clinical scenarios in laboratory settings, where participants reflect on the event with a supervisor (Cant & Cooper 2011). One of the main differences between *post-simulation* and *end-of-day debrief* is the experiences on which students reflect. In the *post-simulation debrief*, all participants have shared knowledge of the same event, that is the simulation. In the *end-of-day debrief*, all participants bring different events to the discussion. In this chapter, I will be focusing on the *end-of-day debrief*, and using that term rather than post clinical conference. I will however, draw on the post-simulation debrief literature, where relevant, as there is a paucity of literature on *end-of-day debriefs.*

Although institutional descriptions of clinical facilitators' roles, as well as their own perceptions of the role, refer to the importance of *end-of-day debrief*s (Rossignol 2000; Sanderson & Lea 2012), there is little research in healthcare education about what occurs in these meetings (Sanderson & Lea 2012). Vezeau (2016) notes that available literature on debriefing is mostly descriptive and written by experienced nurse educators drawing on their practice (e.g. Horsfall 1990; Vezeau 2016) rather than empirical evidence. Horsfall (1990) states that debrief sessions are daily events at the end of clinical shift*s*, where students discuss concerns they have about their experiences that day, and occasionally

about personal matters. They are a 'time and space for students to emotionally and practically disengage from the rigours of the day' (Horsfall 1990, p. 4). The purposes of debrief are reported as integrating theory with practice (Vezeau 2016); creating opportunities for students to talk about emotions (Horsfall 1990; Wink 1995); helping students evaluate their own performance (Davies 1995; Horsfall 1990); solving clinical problems (Davies 1995); encouraging clinical reasoning (Vezeau 2016); developing students' interpersonal skills (Horsfall 1990); and helping students achieve course and clinical objectives (Wink 1995). The perceived benefits of debrief sessions are an increase in student confidence (Davies 1995; Horsfall 1990; Mackenzie 2002); and a broadening in their knowledge and skills (Davies 1995; Mackenzie 2002).

The facilitator's skill in managing the debrief process is pivotal in achieving these benefits (Cant & Cooper 2011; Fanning & Gaba 2007; Horsfall 1990; Manning et al. 2009). Here, the literature on *post-simulation* debriefs is also relevant as these sessions aim to achieve the same outcomes, that is reflection on a clinical experience. Common across all studies is that student participation is essential, and that facilitators should act as guides, or facilitators of learning, rather than didactic teachers (Fanning & Gaba 2007; Trede & Smith 2012; Wickers 2010). Facilitators need to scaffold the reflective process for students (Newton 2011), by structuring 'a seemingly unstructured learning event' (Wickers 2010 p. e83). Although strategies are proposed as to how facilitators can help students reflect (see Horsfall 1990; Wickers 2010), there is scant empirical evidence on how facilitators interact with students to scaffold their learning. The few available studies based on observations and audio recordings have focused on the types of questions facilitators ask (Hsu 2007; Rossignol 2000). Hsu observed debrief sessions in Taiwan and found that facilitators mainly asked questions requiring descriptive responses about content, for example, asking students to describe differences between two clinical procedures. Hsu (2007) noted that unlike other studies, the debrief sessions in her research focused on the cognitive domain, rather than the affective domain. She concludes this focus may have been due to the cultural context of education in Taiwan that emphasises cognitive rather than affective learning. Rossignol's (2000) study also found a predominance of

descriptive questions used by facilitators. However, both of these studies focus only on categorising questions in terms of 'cognitive load', rather than analysing the talk as a social activity.

To my knowledge, the only study on debrief sessions that has analysed participant interactions from a social rather than cognitive view of learning, is that of Veen and de la Croix (2016). Their study differs from mine in that it focused on medical students participating in weekly debriefs following four clinical learning days, and the debriefs were supervised by tutors in an educational setting, rather than clinical facilitators in a clinical setting. However, it offers important insights into the multiple roles played by tutors in managing debrief groups, and illustrates how participant interactions are influenced by the fact that students are not reflecting on a shared clinical event, as in the post simulation debrief. Veen and de la Croix's (2016) study will be discussed in more detail later in this chapter.

As one purpose of the debrief is to discuss student's feelings, it is also considered important to develop trust and a supportive environment (Fanning & Gaba 2007; Fey et al. 2014; Horsfall 1990; Manning et al. 2009). Given that facilitators are also students' assessors during clinical placement, students may be reluctant to discuss unresolved difficulties, fears and mistakes (Horsfall 1990; Trede & Smith 2012). However, Horsfall also notes that some students are willing to voice concerns and take risks, and the way a facilitator responds will indicate to other students, who are observing the interaction, whether debrief is a safe environment to raise mistakes. Emotional support is important because 'even reflection … on comparatively simple clinical events can provoke feelings of insecurity or anxiety and, unless the facilitator is aware of and can manage these possibilities, students' inner doubts may be overwhelming…' (Cleary et al. 2013, p. 73). However, there is scant literature on how facilitators respond to students' mistakes and/or emotions. As well as the pivotal role of the facilitator, the physical environment can also contribute to creating a relaxed atmosphere, which may encourage students to talk about difficult topics. Wickers (2010) suggests placing chairs in a circle, whilst Horsfall (1990) suggests access to a comfortable, private space. However, as

was the case in my study, it has been noted that finding a private space conducive to debriefing can be difficult (Horsfall 1990; Vezeau 2016).

None of the above studies considered participation by EAL students. Mann, Gordon and MacLeod (2009) argue that it is important to accommodate individual differences in learning style, but do not consider linguistic diversity. Trede and Smith (2012) note that students who feel respected and listened to will talk and engage. They also note that the role of student agency plays a part in successful debriefing, and argue that students who ask questions and respond to challenges are more likely to reflect than those who are difficult to engage. As noted previously (Chapter 2), EAL students may not always feel the debrief is a safe environment in which to participate because they do not understand the rules of participation (Yang 2009). At the same time, debrief sessions are a time away from the busyness of the ward where students can consolidate learning, ask questions about things they have not understood, and clarify expectations.

According to Horsfall (1990), *end-of-day debriefs* offers students opportunities to practise interpersonal skills as students talk about their achievements, report on the day, relate personal experiences, and discuss difficulties they had with patients. Horsfall (1990, p. 5) argues that debriefing can lead to a growth in confidence as 'just being able to verbalise fears of inadequacy may allow a student to proceed with some hope of success'. Thus, these are opportunities that could help EAL students, in particular, to further develop their interpersonal skills, including English language communication.

Activity: end –of –day-debriefing

Debrief sessions in each hospital differed from each other: they had different goals, and had different types of participant interactions. Glenda's debrief in Red Hospital was a daily reflection of the whole day, and the only one that was similar to *end-of-day debriefs* described in the literature above. Kim's debrief, in Green Hospital, was an occasional *end-of-day debrief* that focused on students asking questions about medical conditions and terminology. Mel's debrief, in Blue Hospital, focused on

students delivering a nursing handover of one of the patients they had cared for that day.

Finding a physical space for debrief activities was challenging, as no rooms were set aside for use by facilitators and students. Only one facilitator, Glenda, in Red Hospital, managed to locate a quiet space in a comfortable, relaxed environment that she could use on most days. Kim, in Green Hospital, used hospital canteens, and Mel used meeting rooms on the wards, which felt more like a classroom environment, with students seated around a large table. Debrief sessions in Red and Blue Hospital were held in spaces that mostly offered visual and aural privacy to students. In contrast, those in Green Hospital were held in public spaces, and whilst the background noise ensured that students would not be overheard, it also made it difficult for students and facilitator to hear each other.

Table 24 below summarises the key features of each debrief according to the activity and the spaces where it was held. For each debrief, the table identifies the type of debrief, the frame and/or goal of each debrief, and the frequency of the debrief sessions. The table also highlights key aspects of the space where debrief sessions occurred including the seating arrangement, the level of noise, and the amount of privacy the space offered.

All students, both EAL and non EAL attended the daily debriefing sessions. My analysis focuses mainly on interactions between EAL students and facilitators. However, in Section B of this chapter, I include an analysis of an interaction between an EAL student and student for whom English was his first language (Sam).

Table 24: Three types of debriefs

	Red (Glenda)	**Green (Kim)**	**Blue (Mel)**
ACTIVITY			
Type of debrief	Type 1: *Reflecting on daily experiences*	Type 2: *Finding out medical information*	Type 3: *Learning clinical handover of patients*
Frame/goal	**Education**	**Education**	**Education**
	'sharing and caring', and consolidating core knowledge': talking about knowledge and emotions	'ask the expert': talking about new knowledge and experiences	performing as a nurse and a student: learning to do handover
Frequency	daily	intermittent	daily
PHYSICAL SPACE			
Space	patient lounge in common space between wards	indoor and outdoor hospital canteen	meeting rooms on wards
Seating arrangement	armchairs in a circle around a coffee table	chairs around small round tables	meeting table with chairs around it
Noise	distant background noise of hospital machines	significant noise from people in canteen	distant background noise of hospital machines
Privacy level	not overheard can be seen through the window from the corridor but few people passing	potentially overheard can be seen	not overheard can only be seen if staff enter the room

Apart from the challenge of finding suitable physical spaces, was the challenge of determining priorities for 'off the ward' learning of debrief and 'on the ward learning' of the clinical workplace. This tension may account for the differences in the frequency with which students met. Kim, Green Hospital, was new to facilitation and said she was not holding debrief sessions every day as she had been instructed by the university that students should be on the wards rather than

talking with her. Mel, Blue Hospital, and Glenda, Red Hospital, were more experienced facilitators, and prioritised the debrief time. However, comments from Glenda show that she was aware of the tensions between time 'off the ward' and 'on the ward'. She mentioned to me several times that she was not, according to university guidelines, supposed to spend too long away from the ward with students.

As well as differing in location and frequency, debrief sessions differed markedly in the type of e*ducation* frame established by the facilitator and the focal themes discussed. The *education* frame in Red Hospital was a '*sharing and caring*', and *consolidating core knowledge* frame. While the focal themes included core clinical skills and student performance, Glenda also paid attention to the emotional well-being of students. In contrast, the *education* frame established in Green Hospital seemed to be '*ask the expert'*, with a focus on *new experiences* and *new knowledge*, and focal themes of medical terms and conditions. In Blue Hospital, the *education* frame seemed to be a *performance* frame where students learned to perform a key professional discourse, that of *clinical handover*.

The rest of this chapter is divided into two sections: Section A discusses the first two types of debrief held in Red and Green Hospitals. Section B discusses the third type of debrief held in Blue Hospital.

Section A - **End-of-day debrief: a space to reflect and a space to learn new medical information**

Debrief type one: reflecting on the day (Red Hospital)

Glenda met with students at 9pm most evenings when wards were usually quiet and visitors had left. The three wards where students were placed were located on the same floor, and a patient lounge was situated between the three wards (see Figure 4 in Chapter 5). Glenda encouraged students to create a physical

environment conducive to interaction by asking them to pull up the armchairs into a circle.

Glenda's goals for the *end-of-day debriefs* seemed to be: to find out what students had been doing during the day; to check how they were feeling; to make sure they were completing clinical tasks that were listed on their assessment form, in order to confirm that they had the core knowledge required at the level of first year students. As shown in Table 25, there were three main focal themes in Red Hospital. The first theme related to clinical tasks in which students engaged, and the knowledge needed to undertake those tasks. These clinical themes, which aligned to the skills and knowledge domains listed on the clinical assessment form, included checking vital signs; understanding privacy and confidentiality; and hygiene practices. A second theme was the emotional well-being of students. Glenda discussed problems or difficult moments students had experienced, and which students themselves raised in debriefs, for example, caring for patients with terminal illnesses, and death. A final theme was student assessment. Glenda used the debrief to reiterate her expectations of what students should be doing each day, explicitly explained the clinical assessment form, and related topics discussed during the debrief to the assessment form.

Table 25: Focal themes in debrief type 1: reflecting on daily experiences

Debrief type 1: Reflecting on daily experiences		
FOCAL THEMES	**SKILLS AND KNOWLEDGE**	
Clinical tasks/skills	*Clinical skills*	Taking vital signs
	Clinical communication	Communicating with doctors and families
	Privacy and dignity	Confidentiality Privacy
	Risk and Safety	Hygiene practices
Student assessment	*Setting expectations*	Planning patient care
	Monitoring progress	Understanding the clinical assessment form
	Learning in the workplace	Learning from role models
Emotional wellbeing and self-care	*The emotional work of nursing*	Death and dying
	Being a learner	When things go wrong
		Being ignored

What was noticeable about debriefs in Red Hospital was the amount of participation by students. Glenda began by asking students open questions that invited them to talk. These questions were usually 'how was your day', 'how did it go for you today', 'how are you feeling'. Glenda gave students the opportunity to talk before picking up points they raised, and turning them into 'learning moments' (Rizan et al. 2014, p. 902). The following three extracts illustrate how Glenda created learning moments out of focal themes initiated by students. The three extracts illustrate the themes of clinical tasks and skills; and emotional wellbeing and self-care.

Attending to clinical skills: making the ordinary important

The extract below illustrates how Glenda builds on student initiated topics to turn them into learning moments for all students. The pattern of this interaction is an

IRF (Initiation–Response-Follow up) structure with Glenda in control of initiating the interaction; providing a follow up to Ryoko's response; and closing by moving on to an invitation for the next student to make a contribution. However, whereas typical IRF patterns are often characterised by short student responses (Mehan 1979; Sinclair & Coulthard 1975), here, Ryoko has highly extended turns (4, 6), which are encouraged by Glenda's backchannel comment (mm, yes), acknowledging that she is listening (turns 4, 5); and her use of silence. Although Glenda is in control of the overall structure of the discussion, the use of an open question in the initial turn gives Ryoko the opportunity to talk extensively about her own experience. This kind of interactional pattern was present across all of Glenda's debriefs. By inviting students to talk, using open questions and responding positively to their experiences, Glenda creates an atmosphere that encourages participation.

Extract 8: Attending to clinical skills: making the ordinary important

Red Hospital: patient lounge Day 1 Ryoko (student) Glenda (facilitator) Researcher and all students present			
1	Glenda	how did it go for you (2) Ryoko? [*checking name*]	Initiation
2	Ryoko	yes, um (1) my … first placement was just next ward …	Response
3	Students	oh [*said with interest and surprise*]	
4	Ryoko	it is similar … but the (1) … I find some difference … I think … nurses always wear stethoscope ((ah)) they put shoulders but um (1) … this time all of them putting it in their pocket ((yes)) they're little things but ((yes)) … the nurse … I stayed with was really gentle and she was really um (1) … she explained EVERYTHING in details to the um patient before she she does something to them which they care for and very gentle and I thought it was great (1)	R [cont]

5	Glenda	mm . (1)	
6	Ryoko	because um the first placement … the nurses were … busier and I felt a bit rough …	R [cont]
7	Glenda	it's it's really good isn't it when you see a nurse that you think that's how I would like to interact with my patient … if you can sort of give them a bit of your time so that that they don't feel I can't ask her she's too busy … so when you see someone that you think hey I like the way they do those things just watch how their interactions ARE because sometimes they could be working just as effectively ((mm))as someone who's as you say being rough ((mm)) … yes ((mm)) and um I tell you patients really appreciate that ((mm)) feeling of being given time ((yes)) yes	Follow-up/Acceptance & Elaboration

In this interaction, students are learning that they can take the floor and talk about experiences that may seem ordinary but will be valued by Glenda. This extract also illustrates how debriefing can provide students with opportunities for extended turns at talk, and provide facilitators with a broader understanding of their English language capabilities in different situations. Ryoko's participation in this extract is markedly different from that in in other spaces. In *follow up talk about bedside interactions* in the corridor, for example, Glenda controlled the interaction and Ryoko's responses had been minimal (see Chapter 8).

When things go wrong: attending to clinical skills and emotional well-being

The next extract illustrates how Glenda paid attention to both knowledge and feelings. Hua reports that the results she got when she took a patient's vital signs were different from those of her buddy RN. For purposes of analysis, the extract has been divided into four stages. This interaction is analysed using the IRF framework as in previous chapters. However, here, an additional types of F move is identified; that of clarification. Here the facilitator asks a question checking her understanding of something the student said, repeats a word to confirm that what she has heard is correct, or summarises what the student has said with a purpose of confirming her understanding.

Extract 9: When things go wrong: attending to clinical skills and emotional well-being

Day 2: Red Hospital: patient lounge Hua (student) Glenda (facilitator) Researcher and all students present	**Key** I= initiation R= response F= follow-up E=elicitation D = directive Inf = information Eval= evaluation Acc= acceptance Elab = elaboration Clar=Clarification

Stage 1: Recounting the problem

1	Glenda:	how are you Hua today	Initiation
2	Hua	yes I'm fine … but when I did the obs … I did it twice and it's over um 157 ((mm)) and then I told the RN and I thought that maybe she can do it again … it was much higher than that one … his heart rate is about um 87 … and … when she was doing it maybe five minutes … later it was 70 …	Response
3	Glenda:	(2) it was?	F/ Clarification
4	Hua:	it was um 87 before	R
5	Glenda:	when you did it?	F/Clar
6	Hua	yes and when she was doing it was 70	R
7	Glenda	70	F/Clar
8	Hua	and the blood pressure when I was doing it it was higher much higher	I/Inf Restating problem
9	Glenda:	okay (3) did you do you did a manual blood pressure?	F/Acc [okay] & I/E
10	Hua:	yes	R
11	Glenda:	did you then follow it up with the ((yes)) digital one, the electrical one	I/E

12	Hua:	she did it I asked her to double check it	R
13	Glenda:	okay but she [*the RN*] did it doing the electrical ((yes)) one not the manual one ((that's it)) and it was reading lower than	F/Acc [okay] & Clar
14	Hua:	yes	R
15	Glenda:	okay	F/Acc
16	Hua:	but even heart rate heart rate … it was almost 20 difference	I/Inf Restating problem
Stage 2: Finding out student's understanding of what caused the problem			
17	Glenda:	okay um how are you (2) what are YOU thinking might have been the difference at that time	I
18	Hua:	I don't know why but when I told her she just said to me ah you can practise more …	R
19	Glenda:	okay so … how did you …do the pulse the heart rate [*Hua indicates with her hands and ears that she used a stethoscope*] you did it with the stethoscope okay ((yes)) what could you have done to have checked yourself … (1) with the heart rate just go on the heart rate at the moment	F/Acc [okay] & I
20	Hua	*[Hua puts her hand on her pulse]*	R
21	Glenda	yes	F/Eval
Stage 3: Teaching sequence for all students			
22		*[Glenda checks students' knowledge of taking vital signs]*	
Stage 4: Attending to emotions			
23	Glenda:	… but how … did it make you feel when there was such a difference in your results to the nurse's results	I
24	Hua:	(5) oh not very good (3) I just feel that um (4) I felt doubt myself ((mm)) …	R

25	Glenda:	yes (1) don't doubt yourself you could still have been very right okay because the nurse REALLY should have been checking with a manual if YOU'RE using a manual okay otherwise … you're not … comparing together using the same equipment so don't be harsh on yourself okay	F/Acc [yes] & Elab
26		[*Hua reiterates the problem*]	
27	Glenda:	and did you do the checking with the pulse puffing up the cuff	I
28	Hua:	yes I did it … yes I checked everything again	R
29	Glenda	yes good on you … your practice is really good and there may have been a slight difference maybe but … don't accept that what the nurse got on a different machine was the actual correct one	F/Acc [yes] & F/Eval [good on you] & Elab

Glenda's goal in the first stage of this extract seems to be to find out about Hua's day. In recounting an apparent mistake she had made, Hua creates a 'troubles telling' frame. Glenda's turns in this stage mostly clarify the details of Hua's recount. In the second stage, Glenda's goal seems to be to find out what Hua has understood about the reasons for the problem that occurred. In stage three, Glenda's goal is to check students' knowledge of the clinical skill under discussion. This third stage is not analysed in detail here as it deals with technical clinical knowledge. Finally, in stage four, Glenda attends to Hua's feelings, and her goal here seems to be to reassure Hua.

What is noticeable in this interaction is the number of turns that Glenda uses to clarify Hua's story before asking how she feels and evaluating Hua's practice. Glenda could have dismissed Hua's vital sign results as a mistake and a need for more practice, as did the RN. Instead, Glenda takes time to:

- ensure she had understood the readings that Hua got (turns 3,5,7)
- ensure she has understood the actions that Hua took (turns 9,11,13,27)
- find out what Hua understood about the clinical skill of taking vital signs (turns 19,20).

These turns at clarification are similar to findings in Veen and de la Croix's (2016) study, where the supervisor spent time clarifying a student's experience. Taking time to understand the actions and Hua's knowledge enables Glenda to have confidence in her evaluation of Hua's practice.

Once Glenda has understood the event that Hua is describing, she focuses on developing Hua's critical thinking skills. Rossignol (2000, p. 250) proposes that facilitators ask 'high cognitive questions that require students to interpret, explain, infer, or justify one's opinions', in order to teach critical thinking, and this is what Glenda does at the beginning of the second stage of the interaction. However, when Hua is unable to articulate the reasons for the different results, Glenda adjusts her pedagogic strategies by providing more scaffolding for Hua. She introduces a series of elicitations that take Hua through the logical steps of checking that she had completed the skill correctly (turn 19), and narrows the focus of the topic to just the heart rate (and not the blood pressure readings).

Once Hua confirms her understanding of how to check vital sign results, Glenda turns to Hua's emotions. Glenda recognises Hua's 'inner doubts' (Cleary et al. 2013, p. 73), and reassures her by confirming that she had completed the clinical skills correctly. Hua's expression of doubt in her own practice is not unusual. Davies (1995) found that the most common emotions students recalled during reflective activities were doubt, fear and inadequacy.

There are several points in this extract that seem to be influenced by Hua's EAL background. The initial clarification about numbers seems to have occurred because Glenda had trouble understanding Hua's pronunciation. A second point is the way Glenda accepts Hua's physical demonstration, rather than verbal explanations of actions she had taken (turn 19 and 20). Hua's meaning is clear, and Glenda' goal seems to be to check Hua's understanding of the skill, rather than her ability to explain it verbally. Glenda sometimes provides the words for what Hua is doing, as in turn 19 'you did it with the stethoscope okay', and at other times she simply evaluates as in turn 21 'yes'. Finally, Glenda uses silence strategically. When Glenda asks Hua how she is feeling, there is a five second silence before Hua

speaks, and then a three and four second silence as she replies. Whilst silence is an important strategy for all students (Fey et al. 2014; Veen & de la Croix 2016; Wickers 2010), it can be particularly important for EAL students. In seminal work in school education Rowe (1986) found that most teachers leave silences of less than one second after asking students a question, and again after students have responded. As noted in Chapter 3, wait time (Rowe 1986) refers to the use of pauses between teacher-student interactions, and within student turns. Rowe found that when teachers left wait times of three or more seconds, student participation increased; responses became longer and more complex; and students who had previously been referred to as poor performers increased participation, and this was particularly the case with minority students (Rowe 1986). Zarrinabadi (2014) also found that longer wait times increased EAL students' willingness to communicate with teachers. In this extract, Glenda's use of extended wait time (turn 24) gives Hua time to think about her response, and explain how she is feeling.

Glenda's talk in relation to clinical skills is pitched at students' stage of learning in terms of their scope of practice. She focuses on skills that are known to students, rather than new skills and knowledge. In research into students' perceptions as to what influenced them to communicate with teachers, the choice of topic (as well as wait time) has been found to influence their willingness to communicate (Zarrinabadi 2014). That study found that when topics are familiar to students, they are more likely to participate. In this interaction students learn to think about reasons why things might have gone wrong when undertaking core clinical skills with which they are familiar.

Glenda's pedagogic strategies of firstly checking Hua's actions and knowledge and demonstrating supportive listening, before positively evaluating her practice, help build Hua's confidence. Glenda shows other students that debrief sessions can be safe places to talk about mistakes they may have made (Horsfall 1990). In an interview, Ryoko commented how listening to the mistakes of others helped her feel more confident and less concerned about her own abilities.

Attending to the emotional work of nursing

The previous extract shows how Glenda attended to students' emotions when things had gone wrong on the ward. The following extract illustrates how Glenda attends to the emotional work of nursing when caring for patients who are dying.

Extract 10: Attending to the emotional work of nursing: talking about knowledge and feelings

Day 2: Red Hospital: patient lounge Ryoko (student) Glenda (facilitator) Researcher and all students present		
1	Glenda:	how've you gone today on your ward
2	Ryoko:	… um there is one patient who has um cancer um and she got some liquid in her stomach coming up … and she … have been vomiting many times … she really looked tired (2) but … today when I saw her she she got a tube … into her stomach actually the tube was sucking the some liquid from her stomach which made her more feel better …
3	Glenda:	gee
4	Ryoko:	… she can't eliminate anything like in a natural way her stomach has grown bigger and bigger every day and (3) yes that's why they they have to empty some liquid is coming up ... (2)
5	Glenda:	so the thing that they say so there's nothing they can do with her condition
6	Ryoko:	mm terminal terminal? ((yes)) um the nurse … said they had a severe patient …
7	Glenda:	(3) how was it for you being involved with her care how do you feel
8	Ryoko:	mm (11) I think we just maybe for 7 or 8 hours and then um (5) I personally feel really sad to see the patient that are just passing and also the family (3) yes what I always think what I should talk with the family … (5) I think it's (3) I think it's just I have to do what I can do for the patient
9	Glenda:	(3) it's hard sometimes isn't it to as you say what you can say to the family members or to the patient that's involved
10	Ryoko:	yes because I wasn't sure … because it says nil by mouth it means she can't she can't eat anything … but the family kept asking the nurse if

		she can eat anything … I wonder how much the family knows about her her condition and how much how much information the doctor has told the family …
11	Glenda:	(2) yes
12	Ryoko:	(*unclear*)
13	Glenda	(2) and that's one of the challenges you're all facing (2) … it depends on how much information the doctors give to the family as to how … you can determine what YOU can say in relation to the patient's condition ((mm)) what I would say to you to get into the practice with … is if the doctors are going to visit the patient … go with them okay … so that you hear what they're saying to the patient and their family because that way it helps YOU to be able to explain to the patient or reinforce what they do okay and that's part of when they're talking about multidisciplinary communication …

Glenda's goal in this interaction seems to be to understand Ryoko's experience and attend to her well-being. Glenda and Ryoko are the only participants who speak in this extract. The other students listen. Two noteworthy aspects of this interaction are the use of everyday language to talk about the patient's condition, and Glenda's use of silence, which allows Ryoko to discuss her feelings, and introduce her concern about talking to the patient's family. Glenda accepts Ryoko's use of everyday language rather than medical terminology to recount the patient's condition (turn 2). The patient has 'liquid in her stomach coming up'; a tube 'sucking the some liquid from her stomach'; her stomach has 'grown bigger and bigger every day'. Ryoko's description is clear for all who are not familiar with the patient's medical condition. Glenda does not correct her with medical terminology, for example her stomach is 'distended' or 'the tube is draining liquid' from the stomach. Rather she focuses on the content, listens as a person who cares about the patient, and responds with 'gee' showing her understanding of how bad the situation is. Glenda also uses everyday language to summarise the patient's condition, which Ryoko rephrases in a formal way, 'terminal', said with a rising intonation to clarify she is correct. In terms of silence, Glenda leaves a remarkable 11 second pause after asking Ryoko how she felt (turn 7). She also leaves three and

five second pauses within her response. The wait time here give Ryoko time to think about how she is feeling, and to respond.

Glenda plays multiple roles in this extract. She plays an expert procedural role (Veen & de la Croix 2016) in opening and closing the interaction, and a teaching role (Veen & de la Croix 2016) in creating a learning moment from Ryoko's story. However, Ryoko sets the topic of the discussion and has extended turns at talk, and Glenda plays the role of active participant (Veen & de la Croix 2016), listening to her story and responding as other listeners in the group, as shown by her comment 'gee' (turn 3). Glenda's roles and strategies enable Ryoko to tell her story without interruption. Rather than focusing on the clinical content of the story, and using her expertise to rephrase Ryoko's use of everyday language into medical terminology, Glenda responds to Ryoko's story with a predominantly *therapeutic frame*, drawing on therapeutic communication strategies, for example, silence; comments that show she is listening; and open questions (Wickers 2010). In the previous extract, Glenda first attended to knowledge, in order to clarify details about Hua's apparent mistake before attending to Hua's emotions. Here Glenda attends to emotions before returning to her expert teacher role (in turn 13), where she explains multidisciplinary communication and instructs students how to learn from doctors.

In this interaction students are learning to discuss the emotional work of nursing and that debriefs can be safe places to talk about these feelings. They are also learning about the nurse's role in relation to doctors and what and how to communicate with families in difficult circumstances. Finally, this interaction illustrates that students can discuss their patients even if they do not know the correct medical terminology for the conditions.

These extracts illustrate how the physical space, focal themes, and pedagogic strategies adopted by Glenda encouraged student participation, and resulted in students generally talking more than the facilitator, which according to Wickers (2010) indicates a successful debrief. Glenda focused on themes that were within the students' scope of practice, as indicated on the clinical assessment form. She

adapted her interactional patterns according to whether she was listening to ordinary moments or emotionally troubled moments, but what was common to all interactions was that she: achieved an understanding of the students' experience; paid attention to their well-being; and created learning moments for all students in the group. This approach, combined with the quiet space, the daily ritual of debrief, the strategic use of wait time, and the relationship built up among students gave students the opportunity for extended talk which in turn gives Glenda further opportunity to assess their communication.

Debrief type two: finding out medical information (Green Hospital)

Debrief sessions in Green Hospital occurred only four times. On the first day, the facilitator used the indoor hospital canteen, and on the other days the outdoor area of a smaller hospital café. The indoor canteen was very noisy, making it difficult for students and facilitators to hear each other. In the outdoor café, there was less background noise but little visual privacy, as students were in full view of café patrons, hospital staff and visitors. I observed other groups of students participating in debriefs in the canteens, or in the main foyer of the hospital, which suggests that the use of open, public spaces for debriefing may not be unusual.

Kim's goal seemed to be to respond to students' questions, and to share experiences from the day that were 'interesting' or 'exciting'. On the first day, she began debriefing by saying, 'some of you saw some interesting things'. This statement set the tone of the debrief sessions to talk about events that were newsworthy, beyond the ordinary, or beyond students' current practice level. Clare, a student for whom English was her first language, volunteered 'I saw a CT scan and a cannula being put in'. Jing said she went to watch an endoscopy and Maymei saw dialysis. A second question Kim asked in the first and following debriefs was 'is there anything anybody didn't understand'. These opening statements and questions meant that the focus of debriefing in Green Hospital was mainly on unfamiliar medical conditions and terminology that students had heard during the day when caring for their patients, for example, chemotherapy, cytotoxic, heparin, APTT.

I was struck by how little students talked in Green Hospital debriefs. Whilst Kim's opening question invited students to talk, their responses were often limited to asking questions about something they had not understood. Kim's role in debriefing seemed to be that of an expert clinician, passing on new information to students. I also observed that students' participation was constrained by Kim's pedagogic strategies and interactional style. She spoke quickly with few silences and when students tried to gain the floor, they did not often succeed as Kim continued to talk. Kim seemed to ask little about students' experience on the ward. She seemed to assume students were competent in core skills and instead focused on new topics. The extract below illustrates the pattern of participant interactions and focal themes that occurred on the four days of the debrief.

Explaining medical terminology and conditions: an information giving approach

The extract below illustrates how Kim foregrounds the provision of medical terms and conditions, rather than student experiences, and how she controls the flow of information. By the end of the interaction, we know that Angie (as noted earlier, an EAL student) has: seen or heard about APTT; talked with a nurse about heparin; and seen heparin being administered. However, we do not know much about her patient, nor what Angie already understood about heparin and its administration. Again, the IRF framework is used for analysis. In this interaction however, it is the student who used the F move to confirm her understanding, and/or add a related comment based on her experience. She does this by repeating key words that the facilitator uses in the preceding turn before adding her own comment. This move has been coded F/Repetition.

Extract 11: Explaining medical terminology and conditions: an information giving approach

Day 2: Green Hospital: outdoor cafe Angie (student) Jing (student) Kim (facilitator) Researcher and other students present [*number of minutes*] indicates length of participants' turns			
1	Kim	does anyone else have something to look up	Initiation
2	Ang:	I have a question about APTT… what's that	Response &

			I
3	Kim:	[*Kim explains*] …it eventually stops bleeding why [*2.38min*]	R & I
4		[*Angie responds and then Jing talks over her and answers the question*]	R
5	Kim:	[*Kim continues the explanation of APTT*] …what's the problem if the blood is too thin [*1 min. 18 secs*]	R [cont] & I
6	Jing	[*Jing responds*]	R
7	Kim:	yes but what's … the problem for the patient	F/Acc [yes] & I
8	Jing:	they will keep bleeding …	R
9	Kim:	yes… so if they have a stroke and the blood is too thin that could cause them to bleed a lot … what's the problem if your blood is too thick [*26 sec*] (2)	F /Acc [yes] & I
10	Jing:	water they … don't have enough water in the ((Kim: yes)) blood ((Kim: yes yes)) so erm dehydration	R
11	Kim:	mhm what else (2)	F/Acc [mhm] & I
12	Ang:	easy to get a stroke	R
13	Kim:	yes it can cause stroke … it can cause clots …what happens if you have a clot?	F/Acc [yes] F/Elab & I
14	Jing:	hypertension er stroke ((Kim: yes)) stroke	R
15	Kim	Yes PE what's PE, PE is pulmonary pulmonary, P for pulmonary which is the lungs [*Kim explains*] it is caused by a clot and for PE what they almost always do is they give heparin [*1 min. 56 secs*] (2)	F /Acc [yes] I & R
16	Ang:	heparin yeah I heard that ((Jing: oh yeah))	F /Repetition & Comment

17	Kim:	and you would have heard that because you asked me about APTT//	F/Acc
18	Ang:	//APTT yeah	F/ Repetition
19	Kim:	okay so with the heparin what's heparin, what's heparin, what's heparin do	I
20	Ang:	I asked the nurse this er this like er er long acting	R
21	Kim:	mm short acting	F/Eval
22	Ang;	short or long?	I
23	Kim:	I think it's short acting [*Kim explains what short and long acting mean*]// [*44 secs*]	R
24	Ang:	// but the inside liquid is it sodium or?	I
25	Kim:	er yes so it's got the bag it'll be sodium chloride a 100ml bag ((Ang: yes 100mil)) … some you have to add heparin same thing heparin in the bag	R
26	Ang:	I saw a nurse inject the heparin inside//	I
27	Kim	// and then you've got the subcut heparin you might have seen in the morning shift or the some patients have the injection of heparin and some patients have the infusion ((Ang: yes)) of heparin … [*2mins. 54 secs*]	R [cont]

One of the challenges in Green Hospital seemed to be for students to gain the floor, as Kim spoke quickly and left few silences, which limited student participation (Rowe 1986; Zarrinabadi 2014). The interactional pattern in this extract is predominantly an IRF pattern, showing typical features of display type elicitations by Kim, and brief responses by students (Sinclair & Coulthard 1975), which also limits student participation. Students can respond to Kim's elicitations, and they can insert comments, as does Angie. However, Kim either acknowledges the comment but does not probe further (turn 17), or uses the comment to introduce new information (turn 26/7). Unlike, Red Hospital, with Glenda's use of extensive wait time, here, in order to get the floor, students have to quickly latch on to the end of Kim's turns. Angie does this in turns 24 and 26. However, once she has the floor, it is difficult to maintain. Her comment about seeing a nurse administering

heparin on the ward are cut off by Kim who continues her responses by providing more information about administering heparin. Students had to get the floor not only from the facilitator but also from other students, as seen in turn 4, when Angie begins to respond but is interrupted by Jing who completes the turn.

A second factor which limited student participation in Green Hospital debriefs was the choice of focal themes. Whereas sessions in Red Hospital focused on **consolidating core knowledge** that was within the students' scope of practice, the goal of the green debrief seems to be **introducing new knowledge**. As a result, Kim's role is that of expert clinician, and, as illustrated in this extract, she adopts a 'telling' approach, providing large amounts of information to students. The extended response and follow up moves by Kim (turns 15, 23 and 27) range from 44 seconds to 2.54 minutes, whereas the students' turns are mainly one or two clauses long. Whilst focusing on medical terms offers some benefits, it was at times overwhelming for some students. Angie told me the day after this interaction that she had found the information on APTT useful, as it helped her understand the terminology. For Angie, the debrief was an opportunity to ask questions; she had avoided asking questions during Kim's *checking in* activity as she found it difficult to balance the competing frames of *education and patient care*, as well as the interpersonal relationship with her buddy RN (see Chapters 5 and 6). For other students, however, the provision of information turned them into passive participants. Given that the debrief occurs at the end of their nursing shift, students can be both physically and mentally tired (Vezeau 2016) and the facilitator's pedagogic strategies can influence students' ability to stay focused; Hongyan, in an interview, said that she was sometimes tired and her mind was 'off track', as the facilitator spoke so much.

Kim's long explanations resulted in missed opportunities to hear students talk for extended periods. Students' brief responses and the lack of open questions inviting them to talk about their experiences meant that Kim had few opportunities to determine how well students had understood their patients' conditions. Furthermore, the opening questions used by Kim that focused on topics students had not understood meant that, unlike Red Hospital, there were no opportunities

to raise problems that students had faced during the day, and no opportunities for discussing emotions. Whilst students in Green Hospital also faced emotional work, including death, it was talked about in the corridor during *checking in* encounters (see Chapter 6), resulting in missed shared opportunities to reflect on the emotional work of nursing. In sum, the outdoor environment that lacked privacy; the intermittent occurrence of debriefs; the interactional patterns built around IRF sequences which consist of long teacher turns; the minimal wait times; and the focus on new knowledge, limited learning opportunities for students, and opportunities for Kim to gain insight into students' nursing and language capabilities.

Discussion of end-of-day debriefs types one and two

The debrief as reflection: attending to knowledge and emotions

As noted earlier, debrief sessions are seen as opportunities for developing reflective practice and clinical judgement (Vezeau 2016); achieving clinical and course objectives (Wink 1995); and talking about emotions (Fey et al. 2014; Horsfall 1990;). The debrief in Red Hospital (type 1) seemed to offer these opportunities. However, the type of debrief I observed in Green Hospital focused mainly on medical terminology. In this section, I juxtapose debriefs in Red Hospital, (type 1: reflecting on daily experiences), with those that occurred in Green Hospital (type 2: finding out about medical information), to illustrate how goals, frames, focal themes and strategies interrelate to enable or constrain participation by students.

As noted previously, much of the previous literature relates to debrief sessions occurring after a simulated clinical event, when all participants have experienced the same simulated event (e.g. Dufrene & Young 2014; Fanning & Gaba 2007; Fey et al. 2014; Wickers 2010). There is little research in nursing that investigates debriefing at the end of the clinical placement day, where participants draw on experiences that have mainly not been shared by others in the group. In particular, little is known about the genre of debriefs (Veen & de la Croix 2016), and the topics that students bring to these kind of sessions (Holmund, Lindgren & Athlin 2010).

There are some suggestions about pedagogic strategies that encourage student participation, and guide students to think critically (Cant & Cooper 2011: Fey et al. 2014; Newton 2011; Trede & Smith 2012) but as noted earlier, few studies are based on empirical evidence of nursing students, and none include EAL students. My research responds to calls for further research in this area (Cant & Cooper 2011; Hsu 2007; Megel et al. 2013; Vezeau 2016). It provides insights into the goals and processes of debriefs and the strategies that facilitators use that help students participate, guide thinking, and attend to emotions. It also provides some insights into the topics that students raise in debrief sessions.

Reflection in nursing education draws on a range of theoretical perspectives. The definition of reflection that I am using here is drawn from Mann, Gordon and MacLeod (2009), who draw on three theoretical perspectives. Firstly, they draw on Dewey's (1933) argument that reflection is active, careful consideration of beliefs or knowledge. Secondly, they draw on Boud, Keogh and Walker's definition (1985) that reflection means exploring experiences, including emotional experiences to gain new understanding. Finally, they draw on Schön's (1983) definition of the reflective practitioner to revisit experience in order to learn from the problems encountered in practice. In the present analysis, I use the term reflection to refer to the articulation and analysis of both intellectual and emotional experiences, in order to learn from them. According to this definition, Glenda's debrief in Red Hospital was the only one I observed that constituted reflective practice. Glenda attended to both knowledge and emotions as illustrated in Extracts 9 and 10, whereas Kim only attended to knowledge.

Previous studies state that students want to discuss their feelings about the challenges they face during their clinical experiences, but little is known about how this occurs, or how supervisors prepare students for emotional challenges of nursing (Dwyer & Hunter Revell 2015). In their review of the emotional work of nursing, Dwyer and Hunter Revell (2015) conclude that there is increasing evidence of the emotional toll on nurses in providing care; that novice nurses are particularly at risk of developing burnout; and that strategies need to be developed to teach students how to identify and manage these emotional challenges. In

addition to the emotional challenge of patient care, students may struggle with anxiety about their performance in the clinical environment, as did Hua in Extract 9. Jack and Wibberley (2014, p. 90) argue that students need to be able to discuss emotional challenges with somebody who will listen 'and be receptive to their feelings'. The extracts presented here demonstrate how Glenda attends to emotions within debriefs.

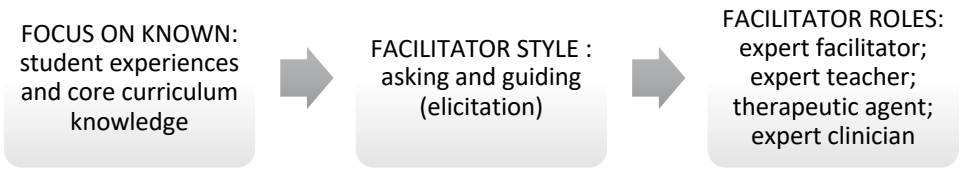
My analysis of debrief type 1, in Red Hospital, shows that guiding students to reflect on emotions and knowledge is dependent on the goal, the type of education frame, the focal themes and the pedagogic strategies adopted by the facilitator. Glenda adopts a range of strategies, and plays a range of pedagogic roles to encourage participation and reflection. These roles include expert facilitator, who can manage a group discussion and encourage participation; expert clinician, who has expertise in the content area; expert teacher, who is working within a curriculum to ensure students achieve the core content relevant to their scope of practice; and a therapeutic agent, who looks after students' emotional well-being. In contrast, in Green Hospital, the focus on new knowledge restricts participation and does not create opportunities for students to reflect. Kim takes on the role of an expert clinician who has knowledge to pass on to students, which results in a 'telling' approach that limits opportunities for students to share experiences about their day.

It is apparent in Red and Green Hospital debriefs that when the focus is on topics which are known to students, that is, the students' experiences and core curriculum knowledge, then students participate more. This finding is similar to that of Veen and De la Croix (2016), who analysed participation in interactions between medical students and supervisors. In that study debriefing revolved around one student's description of a clinical experience and a follow up reflection with the whole group. Veen and de la Croix (2016) demonstrate that when drawing on their experience or feelings, students are more knowledgeable than the supervisor but, at other times, the supervisor is more knowledgeable than the students, for example when drawing on clinical knowledge. Similarly, in Red Hospital, when discussing their experiences and feelings, students were more

knowledgeable than their facilitator. These discussions were encouraged by Glenda's use of open questions, acceptance of ordinary topics and everyday language, strategic use of silence (wait time) and therapeutic communication strategies. Furthermore, when selecting learning points, Glenda chose topics that were part of the core curriculum, for example, hygiene, confidentiality and privacy, which meant students were able to contribute. As a result, Glenda could guide students in their learning, rather than provide them with information. Glenda's management of these focal themes meant she had to adopt numerous roles, including facilitator, teacher, clinician, and therapeutic agent.

In contrast, in Green Hospital the focus was on new knowledge that was outside the scope of students' practice. As a result, the facilitator, Kim, was in a more knowledgeable position than students, and held the floor for most of the debrief. Being in a more knowledgeable position resulted in Kim taking on the role of expert clinician and using a 'telling' approach, akin to Eggin's (2016) declaration strategy, to provide students with information. Kim's fast pace of talk and her minimal use of silence also limited student participation. The relationship between focal themes, the facilitator's pedagogic style, and roles is illustrated below.

Red Hospital: Focal themes and participation



Green Hospital: focal themes and participation

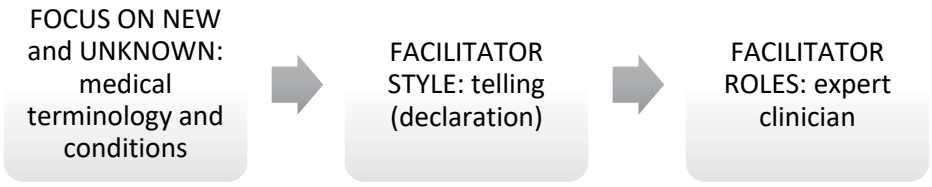


Figure 12: The influence of knowledge and pedagogic strategies on participant roles

Wickers (2010, p. e83) argues that the most successful debrief is where students do most of the talking, as noted previously, and where supervisors are able to structure 'a seemingly unstructured learning event'. While the debriefs in Red and Green Hospitals were both seemingly unstructured in that they depended on students' contributions, either in the form of daily experiences or questions about medical terminology, Glenda 's debrief, in Red Hospital, was in fact tightly structured. The teaching points she raised were related to core curriculum content. She allowed students to share their experience, and then drew from that learning moments that were relevant to all students. In contrast, Kim's approach was more of an ad hoc response to questions. While these responses can be beneficial in that they provide just in time learning, for many students, there was no connection to the overall aims of the clinical placement, nor the skills and knowledge on which students were being assessed.

Section B - **End-of-day debrief: a space to learn how to give clinical handover**

Blue Hospital debriefing occurred from the second to the eighth day. Mel, the facilitator, deliberately searched out spaces that she thought were suitable, using a number of meeting rooms on wards, after gaining permission from staff. The rooms offered both visual and aural privacy. However, unlike the relaxed physical space of the patient lounge in Red Hospital, students and facilitator sat around a large table, as if in a meeting or classroom.

The predominant goal of the sessions seemed to be to develop students' clinical handover skills. Handover is a regular nursing activity performed at the beginning and end of each shift, to inform colleagues about patients on the ward. In Blue Hospital debriefs, students performed a handover each day, outlining who the patients were, why they were in hospital, what was happening for them that day, and when they were going home. On multiple occasions, Mel explicitly stated this structured framework that she wanted students to use. At the end of the debrief on

the third day, after students had completed their first handover, she summarised what she wanted them to know:

> … every morning … I'd like you to know why your patient is here … the background history … then once I know who they are, what, which doctor they're under … why are they in the hospital, what's their background illnesses contributing to that admission … I want to know … your assessment and what are you doing for the patient today … and then after that I want to know what you've done about it … and I always want to know …when are they going … home

In providing this framework to students, Mel is encouraging students to handover according to hospital practices and university guidelines. In accordance with the Australian Commission on Safety and Quality in Health Care standard on handover (ACSQHC 2012), clinical practitioners need to use a structured handover procedure. One commonly used frameworks is known as ISBAR. Mel uses informal language to describe each stage of ISBAR, as illustrated in Table 26 below.

Table 26: Clinical handover

ISBAR	**Mel's interpretation of ISBAR**
Introduction/Identify	Who is the patient? Which doctor are they under?
Situation	Why are they here?
Background:	Why are they here? What is the background illness contributing to the hospital admission?
Assessment:	What you are doing for the patient today? What have you done?
Recommendation:	What does the next nurse need to do? What is the plan? When is the patient going home?

In particular, Mel stresses the need to understand why patients are in hospital. This emphasis on patients' diagnoses led to a second focal theme of medical terminology. Mel expected students to be able to talk about, and understand, patients' medical conditions, referring to it as the 'language of science'.

Whilst the overall frame of the debrief was an *education* frame, there was a *performance* frame within that, as Mel expected students to perform as future

nurses. At the beginning of one of the debriefs, Mel said, 'let's just get on as we would professional nurses', that is, give the handover. However, students were also performing as novice students in front of their facilitator (who, as noted previously, is also their assessor), and in front of their peers. The *performance* frame initially seemed to be anxiety provoking for students but their confidence increased as they practised. Binh, for example, said that, at first, she was very shy and embarrassed because sometimes she could not pronounce words correctly and was nervous that other students would not understand her, and would laugh at her, a similar response to that noted by other students (Jeong et al. 2011). However, as her vocabulary increased, she became more confident to participate.

There were three stages to developing students' handover skills. These stages used two activities, setting up the shift in the morning and the debrief in the afternoon.

1. Setting up the shift: individual sessions with students during the morning rounds
2. Handing over to the facilitator: debrief week 1
3. Handing over to a colleague: debrief week 2

Each of these stages is discussed below.

Stage one: setting up the shift

In Chapter 6, Glenda's strategy of *setting up the shift* in the corridor was discussed. Mel similarly undertook a *setting up the shift* activity. However, Mel's activity occurred in meeting rooms or tea rooms rather than the corridor, and focused on students being able to perform a handover of at least one of their patients. In this activity, Mel stressed the framework that she wanted them to use. In completing a handover, students relied on the printed handover sheet that they had received that morning in the ward handover. It contained brief information about patients, including: name; age; gender; diagnosis; background medical history; date of admission; treating doctor; tests; and results.

Learning new medical terminology

The extract below illustrates this first stage of practising handover, and shows how Mel helps a student, Liming, understand medical terminology written on the handover sheet. It also illustrates Liming's agency in confirming and clarifying that he has understood the information.

Extract 12: Setting up the shift: learning new medical terminology

Day 2: Blue Hospital: tea room Liming: student Mel (facilitator)		
1		*Liming has read the word photophobia from the handover sheet*
2	Mel:	so any phobia … in this particular case it's a medical term meaning um aversion to light ((oh)) so they would put dark sunglasses on or ((oh)) …
3	Liming:	so actually they can't see the light directly they need to put sunglasses on …//
4	Mel:	//correct … [(*unclear*)
5	Liming:	even] even the light just like they can't//
6	Mel:	//yes correct … and what else does it say
7	Liming:	um weaknesses G GTS GT GCTS [*trying to read the letters*] x 4 at home and Hx the (2) the … I'm not sure this one and also this one as well [*points to words on the sheet*]
8	Mel:	oh right
9	Liming:	GTCS
10	Mel:	[*looks at the h/o sheet and reads aloud*] weakness (1) clonic tonic seizure x 4 at home (1) you're going to have to learn this stuff but it's okay it's okay because these are the terms that we need … okay one of the most significant and common brain injuries that you can have is a thing called epilepsy (1) have you ever heard of epilepsy
11	Liming:	I heard of it but I'm not sure what's the meaning
12	Mel:	yes it just means … [*explains]* [*1 min. 30 secs*] … [is what
13	Liming:	seizure] if a patient got a seizure that mean she is it that mean he may be overactive …
14	Mel:	not not overactive …our neurons … [*explains neurons*] … they move in what we call a tonic clonic seizure activity … [*2mins. 11 secs*]

15		*[Mel explains further about epilepsy]*
16		*[Liming tries to read a word from the handover sheet. It is an abbreviation Hx and Rx. Mel explains what they mean]*
17	Mel	so that says what history of what
18	Liming	er she got a history of [*tries to pronounce a word*] (2)
19	Mel	we were just talking about it … let me have a look
20	Liming:	is it the um
21	Mel:	epilepsy
22	Liming:	yes epilepsy epilepsy …
23	Mel:	epilepsy epilepsy which is what what does that mean what's going to happen to her if she's got epilepsy (1) she could have a something (1)
24	Liming:	um ah so epilepsy is the neurons inside the brain [they
25	Mel:	beautiful] high 5 to that you've got it
26	Liming:	can I say that there is a neuron inside the brain they not working in order
27	Mel:	correct
28	Liming:	yes so that's why the patient … when they the movement or … their vision is not working properly because the neuron in the brain is not according to the way that they should have
29	Mel:	beautiful okay …

In this extract, Liming learns three new medical terms: photophobia; epilepsy; and clonic tonic seizure. As well as learning the terms, he also gains a basic understanding of the process of epilepsy and medication for epilepsy. He also learns abbreviations for treatment (Rx) and history (Hx). All of these terms are written on the handover sheet for one of his patients (there are more than these three medical terms on this patient's handover, but these were the ones that were new for Liming). Up to turn 17, the interaction pattern is predominantly one of Liming asking for explanations of medical terms and Mel providing lengthy follow up explanations.

Liming works hard to participate in this interaction. I noticed throughout the placement that students needed to be assertive if they wanted to gain the floor

when Mel was talking. There are few silences and only one request for a confirmation that Liming has understood (turn 24), yet Liming manages to confirm his understanding by interjecting with his confirmations (turns 3, 5, 13, 26, 28). Not all students managed to gain the floor in this way. Similar to Kim in Green Hospital, Mel seemed to see her role as that of providing students with information they did not know. On the sixth day, during a similar individual activity with Mouy, Mel said to Mouy:

> I'll give you my knowledge alrighty I just want to make that perfectly clear okay that's my job to give you my knowledge you have to take it …

The *setting up the shift* activity provides Liming an *education* frame where he can learn new medical terms and conditions. Mel also uses this time to make sure that she can make explicit to students her expectations of what information they need to understand about their patients. Nevertheless, the challenge of learning medical terminology is clear. The entire interaction with Liming from which this extract is taken took 15 minutes. Given that facilitators have approximately eight students to supervise, it would not be feasible to spend this time each day with students to talk about patients – as well as attending to the other activities in other spaces. However, by undertaking a *setting up the shift* activity at an early stage during the placement with each student, Mel is accustoming students to reading the handover sheet; noting new terminology; and setting expectations that they find out what the terminology means so they can describe why their patients are in hospitals. In terms of how to find out that information, Mel suggested to students that they ask patients, RNs or the facilitator. She also suggested to students that they could learn from the brochures on their wards that were designed to educate patients about their medical conditions. In this way, Mel guides students to become agentic learners (Billett 2011).

Learning terminology and gaining an understanding of these conditions presented a significant challenge for students, which Mel may have at times underestimated. Below, in Table 27, are the medical terms for the patients that three of the students handed over to Mel in these individual sessions on the second day.

Table 27: Medical terminology in handover sheets

Binh	nephritic; pulmonary embolism; congenital; dialysis; clexhane (medication); U/S-ultrasound; neurovascular obs
Liming	epilepsy; photophobia; clonic tonic; seizure; Hx; Rx; Epilon (medication); radiologist; radiographer
Mouy	Paraesthesia; acute pain; chronic pain; acute on chronic pain; IHD ischaemic heart disease; stent; CABG Coronary angio by pass graft; atherosclerosis; stenosis; Hx; Rx; GORD gastric oesophageal reflux disease; HTN hypertension; glaucoma; analgesia; patch; narcotic drugs; aspirate; micro discectomy

Whilst all students had to learn new terminology, EAL students seemed to find it particularly challenging. During a *setting up the shift* activity with Mouy, Mel implied that Mouy needed to learn more about the terminology and conditions of her patient:

> you're going to be very busy today find out all of this but it's fine you only have to learn it once

Rather than learning it once, however, Mouy told me that she gained some understanding about the terminology during clinical placement but then needed to go home and research it. She did this either by asking a friend who was an RN, or by looking it up on the internet. Mouy felt it was much harder for EAL students to learn about the medical conditions because it was not only the terminology they may be unfamiliar with but the general vocabulary used to explain the condition.

Stage two: handing over to the facilitator in the debrief

The second stage of learning handover occurred on the second and third day in week one. Students gave a handover to the facilitator, in front of the whole group, and Mel followed up with questions. During these handovers, Mel stressed that students needed to use the framework she had given them. The extract below illustrates how Liming used the medical terminology that he had used in the previous *setting up the shift* activity with Mel (as discussed above).

Giving handover: using new terminology

Liming:

> so er bed xx (,) she's 41 years old (,) she admitted to hospital at [*date*] (,) and she's under dr [*name*] and she re-present with headache and **photophobia so she can't see much light** and she the reason she come to this hospital is because she .. have the **clonic tonic er seizure** (,) GTCS 4 times at home and she's er yesterday night she complained she … still felt pain on the head so we offered the panadol for her and er report from the night staff said she … have she have a **epilepsy** yesterday afternoon …

Mel made no comments on this handover other than asking if this was the same patient they had discussed yesterday. Liming said it was a different patient. Given that only one other student was on the same ward as Liming, it is possible that other students did not understand these medical terms, particularly clonic tonic seizure. This emphasis in this second stage seemed to be on **giving** handover and using the medical terminology, that is on the content of handover, rather than other students understanding it.

Stage three: handing over to a colleague

The third stage occurred in week two. Students were placed in pairs and each member of the pair handed over a patient to the other. However, the pair performed in front of the whole group. The student who received handover took notes and asked questions. Mel sometimes added comments or questions at the end, and sometimes interrupted to clarify or provide information. The extract below is between Mouy, an EAL student, and Sam, a student for whom English was his first language.

Extract 13: Giving and receiving handover

Day 6: meeting room Mouy (student) Sam (student – English as a first language) Mel: facilitator Other students and researcher present		
1	Mouy:	um (3) um female patient 70 years of age um she present biliary … sepsis it mean that she got infection in which means increase her fever so yes and she has a history of liver cirrhosis (,) hypertension and asthma (,) GORD (,) um osteoporosis (1) and she got um left T bone fracture
2	Sam:	what was that
3	Mouy:	T bone like
4	Sam:	tibia?
5	Mouy:	like tibia fracture (3) so what we did this morning so we check her blood pressure four q i d four times a day and um … she complain with abdominal pain so we have to check whether she feel in pain or not and she ask me like her planned discharge today but she got like she become like um renal like kidneys is function not properly so um the doctor review her and encourage her to take more fluid intake
6	Sam:	more fluid?
7	Mouy:	yes so what you have to do encourage her to drink more water and at the moment she have left arm IV on at the moment
8	Sam:	so IV running.
9	Mouy:	yes IV running and then
10	Sam:	is it sodium er chloride
11	Mouy:	yes um yes (1) that's all
12	Sam:	(2) um do we know why we have abdo pain
13	Mouy:	(2) um because um she got infection in her stomach … yes so that's why … so yes the doctor review her today as well so encourage her to drink
14	Sam:	um and that's about it I think (1) …
15	Mel:	so you're happy you know what to do what are you going to do for this patient then biliary sepsis …
16	Sam:	um because the abdo pain as well it could be caused by the septic the infection … it could be failure of kidneys or something like that
17	Mel:	kidneys (,) gall (,) bladder (,) pancreas (,)

18	Sam:	exactly
19	Mel:	multiple … did you say she went for a test or a scan or something
20	Sam:	no
21	Mouy:	no she didn't she just the doctor came review her … he said like her kidneys not function properly … so what the doctor ask her to encourage her to drink or take fluid intake
22	Mel:	okay so has she is her gall bladder still in she hasn't had a cholecystectomy has she
23	Mouy:	no
24	Mel:	[*Mel takes the handover sheet*] okay it's probably related to the liver cirrhosis okay … so what's her treatment then did you say I'm sorry
25	Sam:	um just monitor blood pressure
26	Mouy:	yes
27	Mel:	encourage
28	Sam:	encourage fluids um and that's it …
29	Mel:	(3) Mouy did she go home
30	Mouy:	no she not because um yes …
31	Mel:	alright moving right along not bad not bad how do you feel about looking after her though a few things to look up tonight maybe on the way home on the bus
32	Mouy:	sorry
33	Mel:	maybe you should investigate biliary sepsis a little bit more and layer your knowledge and so that you actually learn about another disease process ((okay)) …

The goal of this activity is for one student to give a handover to a second student, who needs to understand enough to take over care of that patient. This activity has a *performance* frame, and students need to perform in two ways: firstly, in giving the handover, they perform as nurses completing a core nursing activity. Secondly, they are performing as students in front of their facilitator (who is evaluating their ability to do a handover), and in front of their peers.

There are three main participants: Mel, Mouy and Sam. Mouy's role is to act as the nurse who has cared for this patient. Her role is also that of a student, as indicated by Mel's evaluation of her performance (turn 33). Mel's role is that of an evaluator

and an expert nurse who has the content knowledge regarding medical conditions. She is in charge of the interaction, controlling the opening and closing. Sam's roles are to act as the nurse receiving handover, and to demonstrate to Mel, his facilitator that he understands how to do this.

The interactions in this extract demonstrate what Eggins and Slade (2012) refer to as the informational and interactional components necessary for safe handover practice. The informational skills Mouy demonstrates are that she structures the handover systematically (Eggins & Slade 2012). Mouy gives the handover according to the framework that Mel had established on the second day.

Table 28: Mouy's clinical handover

Turn 1	Who the patient is and why they are here	Introduction Situation Background
Turn 5	What the nurses have done for the patient today (situation) What the doctor said needs to be done	Situation Assessment
Turn 7	What Sam needs to do for the patient	Recommendation

She demonstrates interactional skills by providing 'framing expressions' to signal the start and end of the handover (Eggins & Slade 2012, p. 225), as well as the intermittent stages. She explicitly signals actions already taken, '**so what we did** this morning '(turn 5); and what the next nurse needs to do, 'so **we have to check** whether she feel in pain or not' (turn 5), and 'so **what you have to do** encourage her to drink' (turn 7). Mouy also demonstrates that she has an understanding of what is happening to her patient that day, and is able to participate in multidisciplinary communication as shown by her understanding of the doctor's assessment and recommendation.

Eggins and Slade (2012) also note the importance of informational and interactional skills on the part of the receiver of handover. Sam uses interactional skills when he checks and clarifies information to make sure he has understood the patient's situation, including her current problems (turn 2), what he needs to do (turn 6 and 8), and what the cause of her current pain is (turn 12). Mel also plays a

role in prompting Sam to check that he has understood the information. She checks in turn 15, that he knows what he is going to do. In using these interactional components, Sam also helps Mouy use correct medical terminology. He provides complete words for the abbreviations that Mouy uses (turn 2); and rephrases Mouy's 'she has an IV on (turn 7) to 'IV running'. In both instances, Mouy repeats the words and phrases Sam uses. He also encourages Mouy to provide more information (turn 10 and 12). Sam's negotiation of meaning to ensure he is practising safe handover also contribute to Mouy's appropriation of medical terminology.

Mel focuses mainly on medical processes. From turn 15-19 and 22-24, Mel and Sam discuss the possible medical diagnosis and reason for pain, and Mel, after taking the handover sheet and reading it, verbalises her thoughts about what is causing the pain (turns 22-24). The focus on new information that is beyond the core curriculum may appeal to students like Sam who Mel says is her 'star student'. However, the focus on medical information can limit participation for some students. In the extract presented here, Mouy does not seem to fully understand the medical process of biliary sepsis, nor the problem with the kidneys as indicated by her hesitant response in turn 5 where she uses 'like' several times, as she tries to explain that the kidneys are malfunctioning. She does not contribute to the discussion about the medical reasons why the patient may be in pain.

Mel's focus on the medical terminology and conditions is also apparent in her evaluation of Mouy's performance (turn 32), where Mel tells Mouy that she needs to find out more about biliary sepsis. What is not focused on by Mel are some of the points that Mouy has mentioned that are within her scope of practice as a first year student; for example, Mouy's awareness of the doctor's information (turns 13 and 21) - what Glenda pointed out in her debrief was multidisciplinary communication, nor are emotions focused on. Although Mel asks Mouy how she is feeling looking after this patient (turn 31), she leaves no wait time for Mouy to respond. Nevertheless, this extract illustrates the benefits for students in performing handover in front of peers, and learning how to perform like future nurses; it is an

opportunity that enables legitimate peripheral participation (Lave & Wenger 1991).

Discussion of end-of-day debrief type three

A guided approach to performing a clinical handover

The debrief in Blue Hospital offers insights into how facilitators might introduce an approach to debrief that requires students to provide information about patients in a structured manner (Sanderson & Lea 2012). Mel provided students with a structured framework and opportunities to practise performing clinical handovers. Clinical handover is a key nursing activity that students need to learn. Effective handovers have been found to be important for patient safety (ACSQHC 2012). However, performing handover can be anxiety provoking for all students (Collins 2014; Kostiuk 2015), and, as noted previously, particularly for EAL students. Studies have found that repeated practice and use of a structured framework, such as ISBAR, can help increase students' confidence in performing handover (Collins 2014; Kostiuk 2015; Malone, Anderson & Manning 2016). A literature review into how students develop skills in handover found two main arenas for learning: simulation and the clinical learning environment (Malone, Anderson & Manning 2016). While this latter study found some suggestions for improving students' handover skills within an education environment, it was found that there was a paucity of literature on how to help staff and students in the clinical environment develop handover skills.

My study adds to this research as Mel's (Blue Hospital) use of the debrief to practise handover established an *educational frame* which required students to draw on authentic data and their daily experiences of caring for patients in the clinical environment. Handovers were presented within an *educational frame*, in a space that was aside from the 'real-life' handovers on the ward. The handover practice is a simulation, presented to peers and the facilitator for the purposes of practice. The three stages Mel develops, as discussed in this chapter, illustrate how facilitators can scaffold the process of learning handover by using a simple framework, and by progressing through three stages: firstly students are

introduced to the framework, and can use the facilitator's expertise to learn new terminology; secondly, students perform to the facilitator in front of the group, focusing on the delivery of the information; and finally students interact with a peer in front of the group. In this latter stage, both the student handing over as well as the student receiving information interact to negotiate meaning.

As noted previously, Eggins and Slade (2012) argue that both the interactional and informational components of handover are important. My research illustrates how students at a novice level can begin to interact in this way within a peer group setting. At the same time, facilitators can monitor the interactional skills of students, as well as the ability to use the structured framework, and use medical terminology. In groups of linguistically diverse students, this staged approach also provides opportunities for students from diverse language backgrounds to negotiate meaning with each other, a skill they need to develop for the workplace.

Conclusion

This chapter show that facilitators hold different views about the purpose of debriefing, and use a range of pedagogic strategies which results in differing learning outcomes for students. In Red Hospital, the facilitator drew on a holistic view of education, paying attention not only to knowledge but the students' emotions and the need for self-care. In Green Hospital, the focus was on information transmission, and students' learning was mainly limited to acquiring knowledge about medical terms. In Blue Hospital, the focus was on learning one of the key responsibilities of nursing, that is, understanding and handing over information about the patient.

The data from Red Hospital provide evidence for strategies facilitators can use to encourage participation in debrief, and to facilitate talk that focuses on both knowledge and emotions. Unlike previous studies that often consider students' willingness to communicate and demonstration of initiative in terms of personality traits and cultural background (Wang et al. 2008; Xu & Davidhizar 2005), this study demonstrates that variables within the situation, and which the facilitator can influence, can extend or limit participation. In Red Hospital debriefs, students

had opportunities to talk about their day; report details of clinical incidents; negotiate meaning with the facilitator and with each other (although negotiations between students were not illustrated in the data presented in this chapter); 'tell troubles' of things that had gone wrong during the day; and talk about emotional challenges, for example, dealing with death. These opportunities were created by the pedagogic approach and strategies used by the facilitator. Strategies Glenda used that encourage participation, and that are particularly useful for EAL students, are:

- providing a supportive physical environment by choosing spaces that offer visual and aural privacy
- providing a supportive environment by encouraging students to continue talking by using backchannel cues (e.g. mm, yes)
- providing regular opportunities for debriefing by meeting on a daily basis
- asking open questions to enable students to relate their experience
- focusing on knowledge that is within students' scope of practice
- strategically using extended wait time to allow students time to respond to questions and to elaborate on their responses.

The data from Blue Hospital provide evidence for how facilitators can use the debrief to develop the skill of delivering and receiving handover. The strategies used that helped students become more confident in delivering handover were:

- providing a physical space without interruptions
- providing clear framework for students to use in handover
- using *setting up the shift* activities to ensure students understood expectations of handover and to clarify medical terminology
- using debrief to practise the informational aspects of handover in week one
- using debrief to practise the interactional aspects of handover in week two.

Both of these types of debriefs and the strategies adopted maximised learning opportunities for students and provided opportunities for facilitators to assess students' communication ability in English when talking about their patients and

the events of the day. Whilst the Green Hospital offered some learning opportunities in terms of medical information, student participation was limited due to the predominant pedagogic strategy of telling whereby the facilitator provided large amounts of information and left little opportunity for dialogic interaction with students. As a result, there were also few opportunities to assess student's communication ability in English.

Chapter 11 – Conclusion: rethinking clinical facilitation for EAL students

Review of study aims and questions

This study was driven by my desire to understand what happened between EAL students and their facilitators during clinical placement. I had extensive experience in developing and delivering workshops and online materials to help students develop spoken clinical communication skills, and in delivering workshops for facilitators on strategies for supervising EAL students. I had also developed assessment tools to help facilitators assess students' English language during clinical placement settings. However, prior to undertaking this doctoral study, my knowledge of these topics was drawn from the stories facilitators and students told me over the years about their experiences, and from published research that drew mainly on focus group and interview data. In other words, my knowledge - both from my professional work as a teacher and from reading the research literature, was based on what facilitators and students said happened rather than observations of what actually happened. I knew little about the pedagogic practices of facilitators, that is where, when and how facilitators interacted with students during placements. I did not know whether pedagogic practices used in the clinical setting enabled or constrained student learning. In undertaking this study, I wanted to investigate these pedagogic practices, in order to learn how different practices helped students learn about nursing and about the language of nursing. I hoped to use the findings of this study to improve my own practice as a language educator in the healthcare field, as well as contribute to research knowledge in this important area.

The study aimed to investigate the pedagogic practices of clinical facilitators as they went about their daily work of facilitating EAL first year nursing students in hospital settings. The study posed three main questions and four sub-questions:

1. Where, when, and why do facilitators and students interact during clinical placements?

2. What pedagogic practices/interactions are in evidence in clinical placement settings?
   - **2a.** What are the focal themes (topics) of these interactions?
   - **2b.** What nursing skills and tasks do students have opportunities to learn in these interactions?
   - **2c.** What professional and institutional discourses do students have opportunities to learn in these interactions?
   - **2d.** What opportunities do facilitators have in these interactions to assess students' clinical skills/tasks and students' use of professional and institutional discourses?

3. To what extent do these pedagogic practices enable and/or constrain students' opportunities to learn about nursing and about the language of nursing?

After establishing the dearth of research in this area, the study was designed to gain a rich picture of clinical placements from both student and facilitator perspectives, from my own observations, and from analysis of audio recordings of facilitator-student interactions. As discussed in Chapter 4, an ethnographic research design combined with discourse analysis enabled a macro analysis of the broader context and a micro analysis of talk-in-action to investigate the situations, relations and practices that offered opportunities for learning about nursing and the language of nursing. The combination of macro and micro level analysis of interactions resulted in detailed insights into the pedagogic approaches and styles that facilitators used. The ethnographic approach also helped me to understand facilitator and student interactions within the complexity of the clinical setting, and take into account the opportunities and constraints within clinical work environments. The analytical framework that consisted of spaces, frames, focal themes, participants and role relationships, as well as detailed discourse analysis, led to a new way of thinking about clinical facilitation for EAL students.

My research drew on sociocultural theories of learning. The framework of community of practice was useful in analysing the intersecting communities of practice to which students belonged during their clinical placement. The intersection of the local ward, where the buddy RN was expert, and the broader university community of practice representing the profession of nursing, where the facilitator was expert, helped explain some of the challenges students faced in gaining access to learning opportunities. How facilitators managed these two intersecting communities helped focus attention on the importance of the facilitator in guiding students to spaces where the facilitator could act as expert other, and the student as a learner. However, it also highlighted the importance of the facilitator in helping students access the community of practice of the local ward by setting clear expectations and managing relationships between students and nursing staff on the ward. The facilitator was key to students participating in legitimate activities in both communities. Lave and Wenger's (1991) focus on access and participation in activities within the community of practice underpinned the analysis of the activities in which students were engaged. The extra dimension of space that I added, which illustrated that particular activities were inclined to occur in particular spaces, helped explain why some students had more access to learning opportunities than others.

Theories of community of practice and legitimate peripheral participation were enriched by second language socialisation, and the sociolinguistic analysis within that framework. Second language socialisation focused attention on access to, and participation in, legitimate peripheral activities for EAL students in complex work settings. It was central to understanding that a focus on facilitators' pedagogic choices could affect access and participation, rather than focusing only on students' cultural heritage backgrounds. The theoretical frameworks that focused on language were central to understanding how facilitators could enable or constrain opportunities for students to participate in activities, and how they could scaffold their learning of the shared repertoire of the nursing profession.

Summary of key findings

Activities and spaces

1. Where, when, and why do facilitators and students interact during clinical placements?

In response to the first research question, I found that, as might be expected, there are multiple learning spaces in hospital settings. Each of these spaces is associated with particular learning activities between facilitators and students. These spaces and activities offer differing opportunities for learning nursing skills and tasks, as well as opportunities for students to be socialised into the professional and institutional discourses of nursing.

The key spaces within the clinical setting are the corridor; the patient room; the nurses' desk; and a number of different spaces (ad hoc spaces) such as tea rooms, meeting rooms and patient lounges. The activities within each of these spaces were discussed in Chapters 6-10. The activities can help students:

- integrate into the workplace and understand learning (Chapter 6)
- undertake clinical skills like a nurse (Chapter 7)
- think like a nurse (Chapter 8)
- read and write like a nurse (Chapter 9)
- reflect and talk about the emotional work of nursing (Chapter 10)
- and perform a clinical handover like a nurse (Chapter 10).

The spaces offer possibilities for working in different frames, namely, *patient care frames, workplace frames*, or *education frames*. The facilitators' choice of frame relates to their goal for the activity currently being undertaken with the student. When the *patient care frame* is prioritised, the primary goal is to complete patient care in a safe and timely manner. When the *education frame* is prioritised, the primary goal is to focus on helping students think critically about patient care and understand key nursing discourses. The *workplace frame* refers to the daily working life of the hospital, to which both facilitators and students need to adjust and gain access. At times, facilitators focus on this frame to help students gain

access to the workplace. At times, as in the patient room (discussed in Chapter 7), this frame needs to be managed alongside *education* and *patient care frames*. Access to all of these frames helps students to learn about nursing and to learn the language of nursing.

The study also found that movement across these spaces was important in creating different learning opportunities for students. The corridor plays a key role in helping facilitators monitor students' performance, take up learning opportunities as they arise, and guide students to other spaces to pursue relevant learning activities.

However, I found that not all students had equal access to learning opportunities. The pedagogic practices of the facilitator can provide access to or constrain learning opportunities. These practices are discussed below and are the conclusions I drew in response to the second and third research question.

Pedagogic practices

2. What pedagogic practices/interactions are in evidence in clinical placement settings?
3. To what extent do these pedagogic practices enable and/or constrain students' opportunities to learn about nursing and about the language of nursing?

The effective use of spaces and activities was affected by two key practices: firstly, the overall pedagogic approach that facilitators adopted to guiding students to undertake different activities in different spaces; and secondly the pedagogic style facilitators adopted when interacting with students, namely one of *telling* or *asking*. The overall pedagogic approach to guiding students to different spaces was discussed in Chapter 5. Each of Chapters 6-10 discussed the pedagogic styles adopted by facilitators in the different spaces. One of the factors influencing the pedagogic style adopted by facilitators is the focal themes that they chose to pay attention to in each space. Each of Chapter 6-10 also discussed the focal themes of each activity and space. A combination of space, activity, and pedagogic style of the facilitator affects both what students have opportunities to learn, and

opportunities facilitators have to make assessments of students' performance. The next section summarises the key points of this finding.

Three pedagogic approaches to clinical facilitation

Three approaches to facilitation were observed in this study. These approaches affect how facilitators organise their day, and where, how and why they interact with students. The facilitator's overall approach also influences to some extent the focal themes of activities. The approach facilitators use is also influenced by the goals they have for student learning and how they perceive their role as a facilitator.

The first approach to facilitation is an **ad hoc approach**, similar to the ad hoc encounters reported in the medical literature (Morrison et al. 2014; Pearce 2003). This approach was predominantly used in Green Hospital. Here, the facilitator spends time mainly in the *patient care frame* and in the *workplace frame*. Students usually gain access to an *education frame* by directing questions to the facilitator in response to her *checking in* with them, which may result in them moving to a space where the *education frame* is foregrounded. The predominant goal of this model seems to be to respond to student questions and to ensure there are no problems. In this approach, the role of the facilitator is an expert nurse who imparts knowledge to students.

For students who have a high sense of agency and are confident about their English language ability, the ad hoc approach provides a just-in-time form of learning, allowing students to be agentic learners (Billett 2011), who set their own goals and find answers to their own questions. However, this approach has two possible disadvantages. Firstly, many novice EAL students may struggle to integrate into the workplace (Mikkonen et al. 2016a), and the ad hoc approach does not provide them with guidance in integrating into the work setting. Secondly, as found in this study (see Chapter 5), some students may find it difficult to manage the, at times, competing relationships that they have with the multiple expert others, that is, the RN and the facilitator (Rogan et al. 2006). The ad hoc model requires students to gain the facilitator's attention by asking questions and

to leave the patient room in order to move to different spaces with the facilitator for follow up learning activities. In the ad hoc model, students need to be able to move in and out of *workplace* and *education frames* themselves, which may also involve negotiating time schedules and priorities with their buddy RN. Not all students can manage the complex interpersonal work required to do this. As a result, an ad hoc approach may restrict students' access to learning opportunities with their facilitator, where an *education frame* can be foregrounded. The majority of EAL students in my study benefited from a more guided approach where the facilitator directed them to spaces and activities, and negotiated those interactions with the buddy RN.

The pedagogic approaches to facilitation used in Blue and Red Hospital suggest two possible forms of a more guided approach: a **beginning and end of day approach**, as used by the facilitator in Blue Hospital; and a **guided spatial approach**, as used by the facilitator in Red Hospital. In the beginning and end of day approach, the facilitator sets aside dedicated time and space at the beginning and end of the day for students to participate in two activities: *setting up the shift*; and *debrief*. In these activities, an *education frame* can be established to help students learn a key institutional discourse, that of clinical handover. As discussed in Chapter 10, this staged approach to teaching students how to give a clinical handover provides valuable opportunities for students to understand what the facilitator expects them to focus on during clinical placement; to learn important information about the patients they are caring for; and to develop confidence in giving handover. However, if used alone, the **'beginning and end of day' approach** can be somewhat limited, as the structured framework for giving handover excludes other types of activities and interactions which create opportunities for students to participate in different discourses, for example, talking about the emotional work of nursing.

The third approach to facilitation, a **guided spatial approach** to clinical learning**,** integrates an *education frame* throughout the daily activities. In this approach, the facilitator uses the spaces to guide students in and out of the *workplace and education frames*. By repurposing the hospital spaces as pedagogic spaces, where

an *education frame* is prioritised, students can be guided in opportunities to better integrate into the workplace; think critically about patient care; learn to use terminology to refer to specific patient conditions; learn to read patient documentation; and talk about the emotional work of nursing.

A guided spatial approach ensures that all students gain access to all spaces, and hence the differing learning and language socialisation opportunities within those spaces. Each of Chapters 6-10 discussed the learning about nursing and language learning opportunities that each space offered. One disadvantage of this approach is, potentially, the lack of clarity amongst RNs about the facilitator's role. In my study, some students felt uncomfortable at having to explain to RNs why their facilitator wanted to spend time with them. However, this problem could be overcome with better communication between universities and hospitals regarding facilitators' roles.

Guiding students to spaces and activities relied on the facilitator having **intentional learning goals** for students that were based on the university curriculum and clinical assessment form. These goals translated into **focal themes** in each activity. Even though the goals were intentional, they had to be put into action in the moment, as opportunities arose; for example, having observed a student complete a physical skill of taking vital signs, the corridor could be used to spend time in an *education frame*, helping the student to think critically about patient care. The intentional goals related to physical skills; core nursing requirements, for example hygiene practices; and to nursing processes, for example, thinking like a nurse to make clinical judgements. Nursing language was embedded within these goals; however, the focus was on the skill and the process rather than the language needed to complete those activities.

A further important aspect of **a guided spatial approach** is the pedagogic styles used by facilitators. The opportunities created by spaces and activities need to be maximised by adopting a pedagogic style that best takes into account the learning goal, the frame in a given space, and the student's current capabilities, including their current English language performance.

Two pedagogic styles to facilitation

I found that facilitators used two main pedagogic styles that are broadly categorised as *telling* and *asking*. The effectiveness of the style adopted is influenced by the space, the frame, the activity and the focal themes.

The study found that there were different aspects to a *telling* style. They were giving instructions; correcting errors; and providing information. Whilst *telling* can be an effective strategy to provide students with the correct information at the appropriate time, in my study, it was often used in a way which limited student participation in interactions with their facilitators. In some spaces, *telling*, in the form of giving instructions, allows students to carry out clinical tasks that they may not be able to achieve by themselves, for example to undertake a physical clinical skill correctly or to complete a patient chart using correct medical terminology. However, in other spaces and activities, *telling*, which consists of transmitting large amounts of information, restricts students' opportunities to participate. Consequently, this style results in minimal opportunities to hear students take extended turn at talk which can make it difficult for facilitators to assess students' nursing knowledge, as well as their ability to communicate that knowledge in English.

In contrast, an *asking* style, as used particularly in Red Hospital, can encourage student participation in interactions with facilitators and peers. *Asking* can be an elicitation style, where the facilitator helps guide students' learning by scaffolding their clinical thinking process, using questions, prompts, rephrasing and silence to lead students to the correct answer. It can also be an *asking* style where facilitators ask open questions, listen attentively and use silence to allow students extended time at talk. Increased participation by students provides facilitators with more opportunities to hear them in extended talk, providing opportunities for facilitators to make better assessments of their nursing knowledge, including their English language ability.

Focal themes

The focal themes in the study can be classified into known and unknown and planned and contingent. The known focal themes refer to topics with which first year students are expected to be familiar, and which facilitators may have as intentional learning goals for students: for example, hygiene practices and taking vital signs. In that sense, the known focal themes are often planned. However, known focal themes may also refer to topics that the student knows about but with which the facilitator is not familiar, for example, a student's experience that the facilitator did not witness. The unknown focal themes refer to the many unfamiliar medical conditions and institutional discourses, for example, patient documentation that students encounter during clinical placements.

Overall, when facilitators focus on known focal themes, and use an *asking* style, students' participation is increased. When facilitators focus on unknown focal themes, that is what is new for students, and use a *telling* style, student participation decreases. The relationship between known and unknown focal themes and pedagogic style was discussed in detail in Chapter 10.

The analysis of the focal themes in this study also illustrated the kind of nursing skills and nursing discourses that students had opportunities to learn. Students had opportunities to learn to complete physical tasks; to plan patient care; use a process of clinical judgement to think critically about patient care; and reflect on the emotional work of nursing. Students also had opportunities to learn the professional and institutional discourses of nursing. Professional discourses, included: correct medical terminology to refer to patient conditions; and lay terms to describe patient conditions when they were unsure of the medical terms. Institutional discourses included: the specialised use of lay terms in patient notes (for example, gate leave); bedside charts; patient notes, and clinical handovers. However, I also observed that what has been reported as a key professional discourse of nursing, that of small talk, did not receive much attention from facilitators. Given the importance of small talk in building therapeutic relationships, and the reported difficulties many EAL students face in managing

small talk, further research into how students learn to manage this aspect of professional discourse is warranted.

Opportunities to assess students

The pedagogic practices also affected the opportunities facilitators had to assess students' nursing skills and language performance. I found that when students' access to spaces is mostly restricted to the patient room and/or a predominantly pedagogic style of *telling* is used, there are few opportunities to find out what students already know. There are also few opportunities to assess how well they can talk about their patients and their experiences. In contrast, when students are guided to activities in multiple spaces, and facilitators predominantly use an *asking* style, student participation increases. Participation in different activities also means that facilitators can hear and see students using different professional and institutional discourses. As a result, they may be better able to assess their English language ability.

In sum, this study found that effective facilitation of EAL students relies on the facilitator having intentional learning goals for students and creating opportunities for students to achieve those goals by adopting a pedagogic approach that enables students to gain access to different learning spaces and activities. It also requires facilitators to judiciously move between pedagogic styles of *asking* and *telling* to guide students in their learning and help them move beyond their current capabilities.

Contribution to research knowledge

This research is significant for a number of reasons. The methodology used in this study provided insights into clinical education that have not previously been captured. The in-situ ethnographic approach, combined with discourse analysis of actual interactions, allowed me to gain insights that other studies have not been able to capture. The majority of studies investigating interactions between facilitators and EAL students in nursing draw on interview data (Dickson 2013; Duff, Wong & Early 2002; Eyre 2010). Brown (2005) included some fieldwork but did not include analysis of audio recorded data. One of the challenges for

undertaking fieldwork with students during clinical placements is coordinating the logistical challenges of gaining ethics approval, hospital approval and participant consent, long before clinical allocations have been decided. This is to my knowledge, the first study that has managed this process and shadowed students and facilitators for the total duration of clinical placement.

The in-situ ethnographic approach of the study provided a rich in-depth picture of the clinical experience that has not previously been captured. It highlighted the complexities of clinical placements for both facilitators and students in terms of managing relationships, spaces, and activities. The extensive observations provided explanation and context for the discourse analysis of audio recorded interactions (Iedema 2007), which led to my key argument that facilitators' use of spaces, activities, and pedagogic approaches can provide or constrain opportunities for EAL students to participate both in the community of practice of the hospital wards and in interactions with facilitators and peers. The micro analysis of the audio recordings led to a second key argument that the pedagogic styles facilitators use can help or hinder students' opportunities for learning from their facilitator and peers in the clinical setting.

Secondly, this study brings together the field of nursing and of language education. There are existing studies of supervisor-student interactions that bridge language studies and healthcare. Eggins's (2016) study was based on extensive fieldwork and linguistic analysis of audio recorded data (Eggins 2016). Rizan et al. (2014) recorded supervisor-student interactions in GP rooms, a more restricted environment than the hospital setting. However, both of these studies focused on medical students. Furthermore, those students were at a more advanced level than the students in my study. Those studies also did not focus on EAL students. A further difference is the scope of the studies. Eggins (2016) and Rizan et al. (2014) focused on the pedagogic strategies used by supervisors in interactions. My study, however, focuses on the whole educational experience of clinical placement. The analysis of pedagogic styles is one component of my study.

Similarly, in language studies research that investigated assessment practices, Elder et al. (2012) and Woodward-Kron et al. (2012) focused specifically on the comments supervisors made to students about their communication skills with patients in clinical settings. These studies included nursing as well as other healthcare professions. Unlike my study, their research was not ethnographic in nature and focused on single interactions between students and patients rather than situating those interactions within the complexity of the clinical setting, over the duration of a student's clinical placement. Furthermore, those studies did not focus on EAL students.

To my knowledge, this is the first study to provide empirical evidence from actual interactions between clinical facilitators and EAL nursing students in the clinical setting. It contributes to bodies of literature in the areas of nursing education for EAL students; healthcare literature that draws on situated learning and legitimate peripheral participation; and language studies that focus specifically on the role of language in healthcare contexts.

Nursing education for EAL students: the clinical experience

My study has added to the existing nursing literature on EAL students in several significant areas.

Challenges for EAL students in the clinical setting

Firstly, my research confirms some of the challenges that students and their facilitators face in the workplace that have been noted in existing research. In particular, it highlights some of the students' difficulties in integrating into the workplace (Mikkonen et al. 2016a), and of managing the roles of worker and learner (Rogan et al. 2006). It also confirms the linguistic challenges for EAL students in understanding medical terms (Crawford & Candlin, S. 2013; Dickson 2013; Malau & Figlear 1998). Similar to Brown (2005), I also did not observe students making much small talk with patients. However, whereas previous studies have attributed a lack of small talk to students' language ability (San Miguel et al. 2006), the use of extensive observation and language analysis in my study demonstrates that it may have been the space, frame and presence of facilitators

rather than students' lack of communication skills that inhibited them from engaging in small talk.

As in previous studies (Brown 2005; Jeong et al. 2011), there were also reports by one student of discrimination and bullying by an RN. However, unlike findings by Jenkins (2009), in my study, there were no reports from students of feeling their performance was being scrutinised and judged because of their language background. Facilitators in my study demonstrated inclusive attitudes to EAL students. Of course, my presence as researcher with an interest in language may have influenced this finding.

A further challenge for students that has previously been noted is that of reading and writing in the clinical setting. Bosher and Smalkowski (2002) found in a needs analysis of EAL students that producing correct documentation was difficult for students. Dickson (2013) found through interviewing students that reading notes was challenging. My study provides evidence for the kind of challenges students face. It is not only understanding the medical and specialised use of lay terminology, but also the sociocultural knowledge embedded within the documents.

Whilst previous studies have demonstrated how students can learn to write notes by reading those written by expert others (Hobbs 2004; Parks & Maguire 1999), I found that novice EAL students need help decoding notes if they are to use them as models for learning to write. I demonstrate that a guided approach to helping students decode patient notes is important in helping them understand the hand writing, the medical terminology, and the specialised use of lay terminology. It is also important in helping students understand the purpose of reading notes in the overall process of planning patient care. Finally, the analysis in my study demonstrates two strategies, *reading aloud* and *reading alongside* that facilitators can employ in the clinical setting to guide students in decoding notes.

Important factors in facilitating EAL students

Secondly, my study contributes to knowledge about *what* is important in the supervisory relationship between facilitators and EAL students. Previous research in nursing highlights the importance of the interpersonal relationship between supervisors and EAL students for positive clinical experiences (Eyre 2010; Jeong 2016; Lu & Malthus 2012; San Miguel & Rogan 2009). The importance of the interpersonal relationship has also been stressed in the relationship between supervisors and students for all students, not just EAL, in the medical field (Kilminster & Jolly 2000). However, I found that whilst a good interpersonal relationship is an important component of the supervisor-student relationship, much more is needed to ensure that EAL students gain opportunities for learning.

Existing nursing literature tends to focus on facilitators' perceptions of what *students* need to be or do rather than what *facilitators* can do to help students learn during clinical placement. Those studies stress facilitators' views that students need to show initiative, take responsibility for learning and ask questions (Donnelly, McKiel & Hwang 2009; San Miguel & Rogan 2012). In this study, I have used the term agency and agentic learner (Billett 2011) to refer to these behaviours. Previous nursing studies have also noted the challenges that EAL students may have in demonstrating agency in the clinical setting (Donnelly, McKiel & Hwang 2009; San Miguel & Rogan 2012). A lack of agency has tended to be attributed to cultural differences in existing literature (Brown 2005; Eyre 2010; Malau-Aduli 2011).

However, previous literature is predominantly based on what people say rather than what was actually happening in the clinical placement and crucial aspects of the facilitation process and the student experience have been missed. My study adds new insights to previous research methodologies by demonstrating the importance of spaces, activities and pedagogic practices. I offer an alternative view of how facilitators can interact with EAL students in ways that can benefit students who may initially seem to demonstrate low levels of agency, and who may lack confidence in their English language ability.

A guided spatial approach to facilitation provides more equal opportunities for learning for all students. It is an approach that relies less on individual agency and may be particularly beneficial for novice EAL students.

The guided spatial approach also draws attention to the importance of the pedagogic styles used by facilitators. Previous studies tend to attribute a lack of participation to students' cultural heritage or language ability (Wang et al. 2008; Xu & Davidhizar 2005). By drawing on concepts from second language and classroom based research, I have demonstrated that it may be the pedagogic style of the facilitator that is discouraging student participation rather than cultural values.

The pedagogic styles discussed in this study also contribute to knowledge on strategies that facilitators can use with EAL students. Malthus and Lu (2012) noted the importance of the role of facilitators in improving students' communication skills, by encouraging students and providing feedback. That study was based on student perceptions. By drawing on audio recording and linguistic analysis, my study shows *how* facilitators can do this.

Problematic students or problematic pedagogic practices?

Finally, the findings of this study add an important contribution to how the education of EAL students is perceived in the nursing literature. If students' lack of engagement and participation is attributed to cultural heritage or language ability, the student is seen as the problem. However, if students' lack of engagement and participation is attributed, at least partly, to the pedagogic practices of the facilitator, including students' access to space and activities, the problem lies at the level of pedagogic practices. This problem then needs to be addressed at a university level, providing more in depth professional development for facilitators. Whilst there have been previous calls for professional development for facilitators (Brown 2005; Dickson, Lock & Carey 2007; Eyre 2010), as well as calls for teaching methods that benefit EAL students (O'Reilly & Milner 2015; Pitkäjärvi, Eriksson & Pitkälä 2012), there are few suggestions based on research in clinical settings as to what these strategies might be that could inform professional development

programmes. My study offers insights into pedagogic approaches and styles that can benefit both EAL students and their facilitators.

Situated learning and legitimate peripheral participation

This study extends healthcare literature that views clinical learning through the lens of situated learning and a theory of community of practice, where students learn through legitimate peripheral participation (e.g. Bourgeois, Drayton & Brown 2011; Henderson et al. 2010; Le Maistre, Boudreau & Paré 2006; Spouse 1998a). Firstly, my study provides a more nuanced view of how situated learning and legitimate peripheral participation can occur in clinical settings. Secondly, it specifically considers how EAL students can be guided to join the community of practice and participate in legitimate activities.

In order to learn through legitimate peripheral participation, students need access to the community of practice. Previous studies have found that access to the community of practice can be challenging for EAL and non EAL students and that students find it difficult to manage the tensions between being a worker and a learner (Rogan et al. 2006; Spouse 2001; White 2010). My study confirmed that these tensions existed for the EAL students I observed. Spouse (1996) provided a list of categories to help students access the community and engage in participation; these categories include planning, collaboration, coaching and sense making. Henderson et al. (2010) provided lists of activities and strategies that supervisors can use to help students participate, for example, role modelling, demonstration and direct feedback. Similarly, the analysis of spaces and activities in my study shows that facilitators can help students manage these tensions. However, I have also shown that it is not enough to only consider categories or activities that facilitators can do to help students participate. These activities need to be considered and planned within a larger system of a pedagogic approach that deliberately manages spaces, activities, frames and pedagogic styles to help students move in and out of frames to maximise learning opportunities.

My study has added to this previous literature the need for a guided approach to help students integrate into the clinical setting and to ensure they participate in a

range of legitimate activities that offer different learning opportunities. The frame analysis has highlighted the importance for EAL students of gaining access to time with the facilitator in a dedicated *education frame* to help socialise them into the professional and institutional discourses which they need to learn, in order to become part of the community of practice. Previous studies (Spafford, Schryer & Creutz 2009; Spouse 1998b) have argued that students may need more explicit guidance to learn particular healthcare discourses. My study shows how supervisors can provide this guidance by adopting a guided pedagogic approach. In judiciously drawing on *asking* and *telling* pedagogic styles, the facilitator can play a role in working with students in their zone of proximal development to help them move beyond their current capabilities. This is particularly important for EAL students who have the dual role of novice professional practitioner and learning language (O'Neill 2011).

Language studies in healthcare contexts

This study makes a contribution to language studies in healthcare in four main areas: the facilitator's expertise in using language to guide students' learning; the opportunities EAL students have to be socialised into particular professional and institutional discourses of nursing; the content of language programmes that prepare EAL students for clinical placement; and finally, the literature on language assessment practices in the clinical setting.

Facilitators' expertise in using language to guide students' learning

This study adds to the small amount of literature (Eggins 2016; Erickson 1999; Rizan et al. 2014) on how supervisors' pedagogic styles can affect the learning opportunities of students in clinical settings. However, my study differs from existing research in terms of site, participants and roles. Rizan et al. (2014) studied interactions in the GP treatment room where patients, students and the supervising GP were present. As noted previously, this is a more restricted context than my study. Eggins' (2016) research was situated in the hospital setting. While Eggins notes interactions that took place in different spaces, namely, the corridor, the flight deck (the equivalent to the nurses' desk) and a room where doctors were discussing patient care, the emphasis is on the pedagogic interactions rather than their relation to the spaces and activities. Similarly, earlier research by Erickson

(1999) and Pomerantz, Ende, and Erickson (1995) focused on pedagogic interactions between medical supervisor-student interactions in clinical settings but not on the relation between spaces and activities. My study extends this work by expanding on the notion of context and relating pedagogic styles to spaces, activities and frames.

Secondly, my research differs in terms of the roles played by the supervisors in existing research. The supervisors in all of the above studies were supervising students as part of their role as hospital doctors or GPs. Hence, they were also responsible for patient care, and supervision was part of their existing on-going daily work. In that way, the supervisors in those studies were in a similar role to the buddy RNs in my study. In contrast, the facilitators in my study had a dedicated education role, which enabled them to take students away from the daily work of the clinical setting and spend time in an *education frame*.

Finally, my study differs from the previous literature in terms of participants. All of the above studies focus on medical students who are at an advanced stage of their studies. They do not focus on EAL students. My study builds on existing research by demonstrating the important role that pedagogic styles play in creating learning opportunities for novice nursing students at the beginning of their careers, who are from language backgrounds other than English.

Providing corrections: implicit and explicit

My study builds on the pedagogic styles and strategies described in existing literature. Previous studies note the importance of providing corrections and feedback to students and the tendency to provide corrections in an implicit way. Some of these studies have focused on student corrections when not in front of patients (Ferguson 2010; Pomerantz, Ende, & Erickson 1995). Rizan et al. (2014) focused on implicit corrections in front of patients. These studies conclude that supervisors correct in this way in order to build students' confidence and to preserve students' identity as a future professional.

My study has added to this previous research in finding that the space, activity and frame may influence the type of corrections supervisors make. The EAL status of students may also have contributed to some of the findings in my research that differ from previous studies. Firstly, I found that when in front of patients, facilitators made direct rather than implicit corrections. Implicit corrections tended to be made away from patients and when the interaction was predominantly in an *education frame*. I concluded that direct corrections were used as the facilitator foregrounded the *patient care frame* and focused on achieving the task effectively and safely.

The use of direct corrections in front of patients may also be related to the novice status of students in my study as well as their EAL background. In the early stages of their career, students may not have a wealth of knowledge to draw on in order to make self-corrections. Furthermore, when indirect correction was used, as discussed in Chapter 8, it could take time for students to reach the correct answer. Rather than preserving their identity as practising future health professionals in front of patients, as has been concluded in previous studies, the use of indirect corrections with novice EAL students may have caused patients to lose confidence in students' ability. The choice of whether a direct or indirect correction would better preserve a student's identity as a nurse, depends on the students' level of knowledge and their language performance. The disadvantage of a direct correction in front of patients is that it more directly reveals the student's lack of knowledge, and may lead to a loss of face for the student. An indirect correction, as noted earlier, can save face for the student. However, saving face may be dependent on students' ability to quickly self-correct. If the indirect correction leads to an extensive exchange between facilitator and student, and the lack of student's knowledge and or level of English language seems to the patient to be inadequate, it could lead to a loss of face for students. Facilitators need to be able to judge when and how to best correct students in order to better save face and preserve the student's professional identity.

Guiding student to think critically about patient care

There were examples of indirect corrections in my study, but these occurred in other spaces and were usually part of a longer interaction where the facilitator was eliciting information from the student to guide their learning, in particular to think critically. Glenda, in Red Hospital, frequently used this style. Supervisors in Eggins' (2016) study used elicitation as they walked down busy, noisy corridors, on their way to the next patient to help students think about patient care. In my study, the facilitator created a pedagogic space by finding secluded corners of a corridor to stand still and focus on guiding students in their thinking. This example of establishing a space to enter a dedicated *education frame*, the separation from the hustle and bustle of the ward, may be particularly important for EAL students.

Eggins (2016) also noted two types of interaction she refers to as demonstration and declaration. Both of these types fall under the category of *telling* in my study. However, whereas Eggins analysed these three types separately, I demonstrated how a skilled facilitator switches between *asking* and *telling*, depending on the frame, the goal of a particular frame, the student's level of knowledge about the topic being discussed, and the student's level of English language.

Guiding students to think critically about knowledge and do emotional work:

The focus on activities and spaces in my study highlighted the importance of the daily debrief. My study also demonstrates a further form of an *asking* pedagogic style that helps students to reflect on action during the daily debrief. None of the earlier studies mentioned above considered this activity, which differs significantly from interactions that are focused on patient care. There is little existing research on the topics of debrief nor strategies to encourage participation. Existing literature lists strategies that encourage reflection, for example using probing questions to lead students to think of their own answer (Wickers 2010): using what studies refer to as therapeutic communication, that is asking open ended questions, restating student comments, clarifying, encouraging students to talk about their reasoning process (Horsfall 1990; Wickers 2010). The linguistic analysis of actual interactions provide evidence for *how* facilitators do this.

My study also shows that it is not only *how* facilitators interact with students but also *what* they focus on, that is the focal themes they choose to pay attention to, that affects student participation. By analysing focal themes, my research has contributed to the gap in the literature around the topics discussed in debrief (Sanderson & Lea 2012). I have shown that focusing on focal themes that are known to students, combined with an *asking* pedagogic style increases student participation. Focusing on focal themes that are unknown to students, mainly medical conditions, tends to lead to a *telling* pedagogic style where facilitators pass on large amounts of information and student participation is minimal. My findings related to known and unknown themes are similar to the findings of Veen and de la Croix (2016). However, that study focused on once a week debriefs in a university setting with medical students. To my knowledge this is the first study that has investigated actual debrief sessions held during clinical placements. Finally, my study adds to previous literature, the importance of wait time, or silence in increasing participation by EAL students, building on research in the field of education and second language research (Rowe 1986; Zarrinabadi 2014).

Second language socialisation into professional and institutional discourses

Learning small talk

Previous studies have argued that bedside teaching is important for learning communication (Peters & ten Cate 2014; Qureshi & Maxwell 2012). However, there is, to my knowledge, no language studies research that investigates how students learn this important professional discourse in the clinical setting. My study contributes to this gap in knowledge. I found that this is one focal theme that did not receive attention in any of the clinical spaces or activities. Activities in the patient room focus on the clinical skill rather than communication. Furthermore, the multiple frames operating in the patient room, as well as facilitators' tendency to talk **for** the students make it a challenging learning environment. Further research needs to be undertaken to investigate other opportunities students have for engaging in small talk with patients when facilitators are not present. The lack of small talk in the patient room when facilitators are present means that they need to find alternative ways of assessing students' ability to build a therapeutic relationship with patients. This is also an area that requires further investigation.

My study shows that facilitators do model small talk with patients. However, they do not provide any explicit guidance. This is potentially problematic for EAL students as it means that they may be missing valuable opportunities to learn from the role modelling of social talk that facilitators perform when working alongside students.

In undertaking this research, I also observed some of the skills that EAL students bring in talking to patients who themselves do not speak English as a first language. This was not a major focus of this study. However, given the argument commonly proposed in the literature that EAL students can afford benefits to linguistically diverse patient populations (Donnelly, McKiel & Hwang 2009; Klisch 2000; Kossman 2009), it is important that further research is undertaken to investigate how EAL students contribute to the workings of a multilingual ward

Learning to give handover

There is to my knowledge no existing research that investigates how students learn the institutional discourse of clinical handover. My study demonstrates how both EAL and non EAL students can be socialised into this discourse by dedicating regular time during clinical placement to participating in the handover process. The three staged approach discussed in Chapter 10 that was used in Blue Hospital provided students with opportunities to learn the medical terminology related to their patients, as well as the standard structure of handover. Previous research has shown that both informational (the content) and interactional components (the what and the how) are essential to successful handover practices (Eggins & Slade 2012). This study has shown how students can learn to develop both the interactional and informational components of handover by drawing on authentic data from their patients but performing handover in a peripheral way, that is in front of their facilitator and peers rather than on the ward.

Learning to decode patient notes

There is to my knowledge, no existing research that focuses on how facilitators socialise EAL students into the practices of reading patient documentation. As discussed previously, existing research focuses on how medical students (Hobbs

20014) and French-speaking nurses in English speaking hospitals in Canada learn to write notes (Parks 2000; Parks 2001; Parks & Maguire 1999). My study extends that research by illustrating how facilitators can guide novice EAL students to understand the purpose and content of patient documentation. It illustrates two strategies that may be particularly useful for EAL students who may struggle to read handwriting and understand the extensive amount of unfamiliar vocabulary. These two strategies are *reading aloud* and *reading alongside*. It shows how facilitators can switch between these strategies depending on the amount of time they have to dedicate to the activity, and what they judge the student's knowledge to be.

Language programmes that prepare EAL students for clinical placement

Current education programmes that prepare EAL students for clinical placements tend to focus on teaching students professional discourses including interacting with patients and learning medical terminology (for example: Bosher & Smalkowski 2002; Malthus, Holmes & Major 2005; San Miguel et al. 2006). Whilst these programmes have been shown to be beneficial to students (San Miguel & Rogan 2009), they are not enough to address the challenges that students face in the clinical setting, nor to ensure that maximum learning opportunities are available. While Duff, Wong and Early (2000) demonstrated the differing learning opportunities for students during their placements in nursing homes depending on the cultural and linguistic background of residents, my study shows the differing learning opportunities for students depending on the goals, pedagogic approach and styles adopted by the facilitator.

For students, clinical placement is a haphazard process. They are randomly allocated to both the clinical setting and the location. My study demonstrates that not only the pedagogic approach and style of the facilitator, but also the student's sense of agency and confidence in English language can affect their learning opportunities. As well as preparing students to interact with patients and other health care workers, this study indicates that preparation programmes, as well as teaching students the professional and institutional discourses of nursing, also need to help students develop as agentic learners (Billett 2011).

Students need to learn how to maximise the learning opportunities offered in multiple spaces within the hospital setting, particularly if their facilitator adopts an ad hoc approach. Students also need to learn that gaining time with the facilitator can result in learning opportunities that can help them learn both about nursing and the language of nursing. In order to become agentic learners, students need, like Jing in this study, to be able to set their own goals. That means, they need to notice things during the placement that they want to learn about. They need to be able to describe what they have noticed. They need to be able to formulate questions and initiate interactions with the facilitator. They also need to close interactions with the facilitator when they need to return to the ward. My study showed how one student, Jing, gained maximum learning opportunities by taking control of her own learning. Preparation programmes can offer students opportunities to practise the kind of language they need to be confident enough to demonstrate their sense of agency.

Assessing English language during clinical placements

This study confirms previous findings about the assessment of communication skills and English language in clinical settings. Woodward-Kron et al. (2012) concluded from their research that investigated how physiotherapy supervisors commented on students' communication skills in the clinical setting, that supervisors tended to focus on clinical matters rather than communication. In my study, facilitators did not often comment explicitly to students on their communication skills, other than general statements, for example, 'your communication is good'.

However, my study has added to this previous literature in several ways. Although it did not focus specifically on the assessment practices of facilitators, my study illustrates that the pedagogic approach and style of the facilitator and the use of spaces can extend or constrain the opportunities for facilitators to assess students' communication skills. If students only engage in spaces where the *patient frame* is foregrounded, and facilitators adopt a predominantly *telling* approach, there are fewer opportunities for student participation, and in particular, fewer

opportunities for students to engage in extended turns of talk. As a result, it can be difficult for facilitators to make judgements about students' ability to communicate in English. Therefore, future research that investigates how facilitators assess students' English language performance would also benefit from a focus not only on interactions but on spaces and activities.

Secondly, earlier research has focused mainly on spoken language. Similarly, in nursing, the development of frameworks that help facilitators make assessments of students' English language has also focused on spoken communication (San Miguel & Rogan 2015). My study shows that facilitators also need to take into account students' ability to read and write patient documents. Future research that takes into account the assessment of written language in clinical settings would benefit both facilitators and students.

Implications for nursing education

This study highlights some problematic areas of current nursing education that can be addressed at a university level. One of the problematic areas is the apparent lack of clarity about what the important learning goals for first year students are. A second problematic area is the facilitator's role in assessing students' language ability.

Most importantly, this study demonstrates the need for facilitators to draw on sophisticated pedagogic practices in order to offer equal learning opportunities to EAL students. As discussed previously, there is a need for professional development programmes for facilitators to develop pedagogic practices that benefit EAL students. As employers of clinical facilitators, universities need to ensure that facilitators are well resourced and adequately prepared to facilitate the learning of EAL students.

Clarifying learning goals and expectations

Firstly, what is expected of students at a first year level seemed to differ, according to each facilitator. These expectations were not always clear to students, nor to the buddy RNs with whom they worked. In particular, clearer guidelines need to be

developed for facilitators and students about what the overall goals are for students' clinical placements. Students would benefit from more explicit guidance about what they are expected to do in terms of planning patient care, reading about patient care, and handing over patient care. The focal themes in this study, and the concept of known and unknown focal themes may be useful in helping further clarify key expectations. Universities responsible for nurse education would then need to consider how these goals are best articulated to buddy RNs each day.

Language assessment

Secondly, this study confirms that assessing students' English language during clinical placement is a challenging, complex task for facilitators, who may not feel confident to make decisions about students' language performance. This study has not provided insights into how facilitators' can better develop their skills in language assessment. That was not the intention of this study. However, it has shown that facilitators' pedagogic approaches and styles can restrict their opportunities for assessing students' language performance. Professional development programmes could focus on pedagogic approaches and styles that facilitators can adopt to increase participation by students and provide them with opportunities to learn the professional and institutional discourses they need to be part of the community of practice.

A guided spatial approach to clinical facilitation

Most importantly, this study has implications for the way students', and particularly EAL students' learning is facilitated during clinical placement. This study shows that focusing on the need for EAL students to improve their English language, or learn to be independent learners is not enough. Universities also need to focus on the kinds of pedagogic practices facilitators can use to ensure that EAL students have opportunities to learn about nursing, and the professional and institutional discourses of nursing.

Trede and Smith (2012, p. 624) argue that a structured learning approach in the workplace is not appropriate, as a 'well-intended linear logical progression' does

not compare to the 'messiness and diversity of workplace reality'. However, my study demonstrates that what I am calling a guided spatial approach can help students navigate the messiness of the workplace. A pedagogical approach that is guided yet has flexibility, and that uses spaces to create opportunities for students for different learning and language socialisation experiences can help students learn about nursing and the language of nursing. Moving in and out of particular spaces mirrors moving in and out of a space where the workplace is prioritised to one where the learning is prioritised. Facilitators can use these spaces to spend time explicitly guiding students in learning the ways of thinking like a nurse, practising like a nurse, reading and writing like a nurse and talking like a nurse.

This interrelated system of spaces and approaches offers a different way of thinking about clinical pedagogy that takes the focus away from individual characteristics and attitudes, to spaces and pedagogic approaches. The approach relies less on learner agency and a student's level of confidence in their English language ability than do the other types of facilitation, which rely much more on students' willingness to engage in opportunistic, ad hoc encounters. Whilst this study has focused particularly on EAL students, aspects of the guided spatial approach to facilitation may be useful for all students, many of whom face similar challenges during clinical placement, as noted in Chapters 1 and 2.

The key principles of this guided spatial approach are:

- to have clear learning goals for students for each clinical placement: these goals need to include both nursing skills and processes and professional and institutional discourses
- to guide students to spaces, activities and frames to provide opportunities for students to achieve these learning goals
- to use pedagogic styles that enable students to participate extensively in interactions with the facilitator and with their peers
- to use pedagogic styles that help students work beyond their current capabilities.

Implications for my own practice

One of the questions I asked myself throughout this research was the extent to which what I was observing was related to students' language background. A second question I asked myself was how important was English language for students. Often students seemed to be able to perform patient care without talking to patients. Often the facilitators talked for students and left few opportunities for students to talk, both in front of patients and when interacting with facilitators. As I observed students, I made my own informal assessments of their English language performance based on what I was seeing and hearing. However, I too found it difficult to make assessments of some students, either because I did not have enough opportunities to hear them talk, or because their performance differed across spaces and activities.

A further observation I made was that although I had some concerns about several students' English language performance (which I did not mention to facilitators), this was not noted by facilitators. Rather facilitators could see aspects of these students' performance, which made them a 'good' nurse. These were aspects I could generally not notice, and were usually related to the way students were thinking about patient care. However, I also observed that facilitators predicted that students would have problems in second year if their English language performance did not improve. These comments were made to me and to some students.

In many ways, what I have learned about facilitators' role in assessing language is that it is even more complex than I imagined. English language is not a separate skill that students have or do not have but is rather embedded within the nursing skills and tasks students perform. Some students, from my perspective as a language educator, may seem to have low levels of English language. Other behaviours and skills may compensate for a lack of fluency in English. The challenge for facilitators is to determine when students' English language impedes their performance as a nurse. This study has not provided an answer to that question.

However, it has shown that language performance differs across spaces and activities, and that if facilitators are to make assessments about students' English language performance, they firstly need to ensure they create opportunities where students demonstrate their English language ability by taking extended turn at talk and reading. It seems, rather than thinking about 'English language performance', it is, firstly, important to consider which activities in which frames and spaces are priority learning and assessment goals for students. For example, explaining patient care that students have carried out might be a priority activity for learning and assessment; but reading notes might be a learning activity but not an assessable item. These are decisions that could to be made by university educators in collaboration with language educators.

As a language educator, who has devoted time to preparing students for clinical placement, I have learned that professional development for facilitators is just as important. In my experience, students receive more extensive development than do facilitators, which is underpinned by the view that any problems related to EAL experiences are because of students' lack of English or the wrong learning style. However, this study has shown me that changing pedagogic practices of facilitators is equally important.

Limitations of the study

This study was an in-depth study of a small number of EAL students and facilitators. Whilst the study was across multiple sites, all were large urban hospitals. The findings are therefore limited in that they may not apply to other types of clinical settings (for example nursing homes or community nursing). As this study only considered the practices of three facilitators, there may be other pedagogic approaches and styles to facilitation that were not seen in this study. Likewise, as the students volunteered to participate, those I observed may have been more confident in their English language performance than those who chose not to participate. However, the rich descriptions of the activities, spaces and pedagogic practices will allow readers to interpret and assess the usefulness of the findings in relation to their own purposes, settings, and students.

A second limitation is that the study was not longitudinal and hence cannot draw conclusions about the long-term benefits to the pedagogic approaches and styles for on-going learning. In particular, this study cannot draw conclusions about changes in the development of students' English language as it only presented a snapshot of the opportunities students had for language socialisation in the workplace. Although second language socialisation studies are optimally longitudinal to follow trajectories of student socialisation into language practices, the scope of this study did not permit a longitudinal approach across the span of the students' degree. Similar to other workplace studies (see Roberts 2010), it studied the opportunities for socialisation rather than whether students actually made language gains. Longitudinal studies of students across the clinical placements throughout their degree would provide valuable insights into how they are socialised into the language of nursing over time as well as spaces.

A further limitation of this study is that the findings were not discussed with facilitators nor students. Due to the transient nature of casual clinical facilitators and the length of time required to complete the study, returning to participants was outside the scope of this study. Students had completed their degrees and employment statuses had changed. Their views would have added another dimension to the interpretation of data. Nevertheless, my intention is to share these findings to large groups of facilitators and other health academics where discussion about implications and possibilities can occur.

These limitations raise areas of future research, some of which have been noted in the previous discussion. This study observed only three facilitators and their students. The findings of this study could be further validated by ongoing collaborative research with facilitators and nurse academics to challenge and develop the proposed guided spatial approach presented above. There is also a need for more research into how facilitators assess students' language ability in the clinical placement, including their ability to read and write institutional discourses. Further research on how students learn the professional discourse of small talk is also required.

Concluding remarks

This study presents, to my knowledge, the first observational and audio recorded data of interactions between clinical facilitators and EAL students in the clinical setting. The findings demonstrate that pedagogic approaches and styles of facilitators affect how EAL students integrate into clinical settings and gain opportunities for learning nursing, including the language of nursing. The study provides a platform for professional development for clinical facilitators; clinical preparation programmes for EAL students; and further research into nursing education, second language socialisation and language assessment in the clinical setting. Finally, whilst this research focuses on the education of EAL students in nursing, the findings may also be of interest to researchers and practitioners involved in workplace learning for EAL students in other professional areas.

I conclude with a summary of recommendations made throughout this chapter.

Recommendations

University nursing curriculum design

- clearer guidelines to be developed for facilitators and students about what the overall goals are for students' clinical placements
- decisions to be made as to how these goals are best articulated to buddy RNs each day
- goals to explicitly include the institutional and professional discourses of nursing (both spoken and written language)
- distinctions to be made between goals that are to be included as assessments and goals that are for formative feedback only
- university educators and language educators to collaborate in articulating goals related to professional and institutional discourses.

Professional development for facilitators

- universities to ensure that facilitators are adequately resourced and prepared to facilitate EAL students

- professional development programmes for facilitators to be developed that focus on pedagogic approaches and styles that:
    - increase participation by students in workplace settings
    - increase participation by students in interactions with peers and facilitators
    - provide students with opportunities to learn the professional and institutional discourses they need to be part of the community of practice.

Professional development for language educators

- language educators to spend time in relevant workplace settings to develop their knowledge of language learning in the workplace, in order to better inform curriculum design.

Clinical preparation programmes for EAL students

- language preparation programmes to include strategies that help students develop as agentic learners (Billett 2011).

Future research

There is a need for research that investigates:

Learning in clinical settings

- the role of written language during clinical placements: how students learn it and how facilitators assess it
- opportunities students have for engaging in small talk with patients when facilitators are not present
- facilitators' practices in assessing students' ability to make small talk with patients in order to build a therapeutic relationship
- the benefits that EAL students can bring to the workings of a multilingual ward
- longitudinal pathways of students across the clinical placements throughout their degree focusing on how students are socialised into the language of nursing over time as well as spaces.

Language assessment

- the impact of space and activities on the workplace assessment of students' communication, including English language
- the threshold at which students' English language competence impedes their performance as a nurse.

Appendix 1: Student participants

Student name	International /domestic	Country of birth	Gender F/M	Relevant work experience	Previous education in Australia
Red Hospital					
Soo-Jin	international	Korea	F	community worker aged care	Community welfare (TAFE)
Ryoko	international	Japan	F		Cert IV academic English (TAFE)
Hua	international	Taiwan	F	works in the welfare sector	Welfare certificate from TAFE (2 years)
Mingxia	domestic	China	F	RN qualified overseas works in a medical centre	
Ravindra	international	India	M		
Hannah	domestic	Australia	F		
Emma	domestic	Australia	F		
Blue Hospital					
Liming	international	Hong Kong	M	nursing home	Foundation course/accounting
Mouy	domestic	Cambodia	F		HSC in Australia (but speaks a lot of Vietnamese)
Binh	domestic	Vietnam	F		English for academic purposes (1 year)
Dilip	domestic	Nepal	M		Commercial cookery (2 years)
Narinder	domestic	India	M	AIM (assistant in nursing) –hospital setting	Business management qualification
Sam	domestic	Australia	M		

Student name	International /domestic	Country of birth	Gender F/M	Relevant work experience	Previous education in Australia
Jo	domestic	Australia	Female		
Green Hospital					
Angie	international	Indonesia	F		Diploma in tourism (private college, 2 years)
Maymei	international	Malaysia	F		Commercial cookery (2 years) Tourism (private college, 1 year)
Jing	domestic	China	F		Foundation studies/ business (1 year) Business studies degree (2 years university) Certificate Teaching English to Speakers of other languages
Hongyan	domestic	China	F		Laboratory work diploma (TAFE) (lived in Australia for 6 years)
Nisha	domestic	Nepal	F	Working in a nursing home	
Priya	domestic	Australia	F		
Claire	domestic	Australia	F		

Appendix 2: Extract from data analysis, 'patient room to corridor'

WHERE	WHEN	WHO	WHAT	FOCUS	HOW	LANGUAGE	RECORD
patient room and then corridor RH	Day 2	Glenda and Ryoko	OBSERVATION AND FEEDBACK; see student who had just done BP; setting up learning opportunity to help doctor; feedback on what Ryoko had observed with the patient; completing charts	noticing things about patients when doing obs; completing charts; what action to take next with pt; - arranging follow up action; who to report what to	asking questions to guide sts to answers; waiting time; modelling what to write for students; what I would do next - (instruction?)	nursing terminology to write on chart to describe pt.'s condition;	DS400574
patient room and then corridor RH	Day 2	Glenda and Ryoko	OBSERVATION AND FEEDBACK: Follow up to patient who is short of breath- return to check respiration followed by completing charts	noticing things about patients when doing obs; completing charts; who to report what to	CF observes Ryoko doing activity; Cf physically points out to Ryoko what to do with stethoscope and where; CF models what to write on chart	CF talks FOR Ryoko- she asks pt if Ryoko can listen to her chest; CF talks FOR Ryoko by reporting pt.'s condition to RN; specific nursing terminology to describe Pt.'s condition that Ryoko has observed	DS400574-00.14 – 8.17-8.17 mins

Appendix 3: information for clinical facilitators

Research project:

Educating nursing students from diverse backgrounds: the clinical experience
(HOSPITAL HREC NUMBER & UTS HREC NUMBER)

Who is doing the research?
My name is Caroline San Miguel[2] and I am a PhD student in the Faculty of Arts and Social Sciences at the University of Technology, Sydney. My supervisor is Dr Ross Forman (email address).

What is this research about?
I am inviting clinical facilitators to participate in a research project which aims to investigate student learning and supervision practices during clinical placement. I am particularly interested in students for whom English is a second language (ESL). Research questions include:
What learning and teaching practices/interactions are evident in the clinical settings?
What attention is given to language and culture in this pedagogy?
How do clinical facilitators perceive that students learn during the clinical placement?
How do students perceive their learning during clinical placement?
What factors do clinical facilitators consider when making decisions about ESL students' overall assessment during clinical placement?

I am seeking clinical facilitators to participate in my research. I would like facilitators who:
Have two years' experience
Have some experience in facilitating ESL students
Are willing to facilitate at one the following hospitals: NAMES OF HOSPITALS
Will be working as a NAME OF UNIVERSITY clinical facilitator in spring/summer semester 2013-2014

What will it involve?
The researcher will select clinical facilitators who have agreed to participate and who are allocated to work at one of the research sites where the study has been approved. If you agree to participate and are in one of the sites the researcher is observing, she will contact you via email or telephone before the clinical placement block to confirm with you which clinical placement block she will be attending.

The researcher will 'shadow' you for a two-week block as you go about your daily practice when supervising first year nursing students. This will demand no extra time from you. She will observe group supervision sessions you teach as well as interactions you have with individual students. Some interactions will be audio recorded where feasible and non-intrusive, if both you and students agree. You will also, at times, be audio recorded during short, informal conversations about your daily practices during the observation period. The researcher will ask you to attend two follow up interviews for approximately one hour each. The first will be held soon after the clinical placement the researcher observes and she will ask you to talk about your experience of the clinical placement. The

[2] During my candidature, I changed my family name from San Miguel to Havery.

second will be held after the researcher has analysed the data. She will show you a summary of her analysis of the data and ask you for any comments you would like to make about the analysis. The interviews will be arranged for a time that is mutually convenient and will be held at UTS. All data will be kept confidential. The audio recordings will be transcribed but real names of participants and clinical settings will be replaced with pseudonyms.

Are there any risks?
There may be an initial sense of embarrassment at being observed and audio recorded. However, a small digital recorder will be used and the researcher will position herself as unobtrusively as possible. You can ask to stop recording at any time if you feel embarrassed or anxious. All data will be kept confidential.

Are there any benefits?
You may benefit from the opportunity to reflect on your teaching and assessment practices. In the long term, the research should result in greater understanding of supervision and assessment practices for students, particularly ESL students. Participants who are interested will be informed about any research publications and presentations that arise from this research.

Do I have to say yes?
You do not have to say yes

If I say yes, can I change my mind later?
There will be no negative consequences if you do not wish to participate in this research. If you agree and wish to withdraw at a later date, you will be able to withdraw at any time until data collection is completed.

Questions
If you have any questions you can contact the researcher: Caroline San Miguel CONTACT DETAILS or you can contact her supervisor Dr. Ross Forman, CONTACT DETAILS

Ethics approval and questions/complaints

Note: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee (UTS HREC REF NO). If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (CONTACT DETAILS). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

This study has also been approved by the Ethics Review Committee (HOSPITAL ZONE) of the LOCATION Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on CONTACT DETAILS and quote protocol number XXXXX

Appendix 4: information for students

Research project: Educating nursing students from diverse backgrounds: the clinical experience [UTS HREC & HOSPITAL HREC NO]

Who is doing the research?
My name is Caroline San Miguel and I am a PhD student in the Faculty of Arts and Social Sciences at the University of Technology, Sydney. My supervisor is Dr Ross Forman (email address).

What is the research about?
The purpose of the research is to find out how first year nursing students experience their clinical placement. The researcher (Caroline San Miguel) is interested in finding out:
how clinical facilitators and students meet and talk with each other during clinical placement
the extent to which language and culture affect the way students and their facilitators talk and interact with each other
what students' and facilitators' opinions are about how students learn during clinical placement
how facilitators decide whether students' work is assessed as satisfactory

What will it involve?
If you agree to participate, you will be asked to fill out a consent form and complete some questions about the language you speak at home, and whether you are an international or local student. This information will help the researcher to choose groups of students to include in her research. The researcher will be visiting five clinical placement sites.

If you agree to participate, and are in one of the placements the researcher attends, she will observe and make notes about what happens during your two week clinical placement block during spring and summer semester 2013/14. She will also:
-talk to you when you have time during clinical placement to find out your opinion about your clinical placement experience.
-invite you to attend an interview after clinical placement to talk about your experience. This interview would be held at UTS at a time that suits you.
-if you are willing, make a copy of your Clinical Assessment Form for the placement. The researcher will remove your name and student identity number from the copy.
make audio recordings of conversations and interviews when possible

The researcher will keep anything you say private. She will not use your real name or the name of the hospital in any presentations or publications arising from the research. She will not discuss anything you tell her with your clinical facilitator or with academics at your university in a way that identifies you. The audio recordings will be transcribed but she will not use your real name. The transcription would look like this, with any student represented as 'S' and the clinical facilitator as 'CF' (or a pseudonym –a false name):

S: I thought she'd understood but she was just nodding
CF: Why do you think patients-people do that?
S: I think maybe they don't want to like cause any trouble by getting it clarified and they might think that we assume they understand and they'll just go along with it and won't cause any problem
CF: Yes, that's excellent and it'll be a great learning experience for you, to be able to follow the patient right the way through

If you do not agree to participate but are in a clinical group where the researcher is observing other students who have agreed to participate, she will not make any audio recordings when you are present and she will not make any notes about you.

Are there any risks?
At first, it might feel a little strange or embarrassing when the researcher observes and records what is happening. However, she will only use a small digital recorder. You can ask to stop recording at any time if you feel embarrassed or anxious. The researcher will keep all information private so nobody will be able to identify you when she talks or writes about the research. She will not use your real name or the real name of the hospital so that your identity will be protected.

Are there any advantages for me?
You will have the opportunity to talk about your experiences and to give your opinion about learning during clinical placement. If you are interested, the researcher will give you a clearly written summary of the main findings of the research.

Why have I been invited?
All first year nursing students are being invited to participate. Clinical placement is an important part of your degree and the researcher can find out more about how students learn and how facilitators supervise you by observing and analyzing what happens during clinical placement.

Do I have to say yes?
You do not have to say yes.

If I say yes, can I change my mind later?
You can change your mind until the researcher has finished collecting data. If you decide to withdraw from the study, there will be no negative consequences.

Questions
If you have any questions you can contact the researcher: Caroline San Miguel Room CONTACT DETAILS or you can contact her supervisor Dr Ross Forman, CONTACT DETAILS

Ethics approval and questions/complaints
Note: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee (UTS HREC REF NO). If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (CONTACT DETAILS). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

This study has also been approved by the Ethics Review Committee (NAME OF ZONE) of the NAME Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on CONTACT DETAILS and quote protocol number xx

Appendix 5: information for hospital staff

[Insert photo of researcher here]

Research project: Educating nursing students from diverse backgrounds: the clinical experience [HREC approval no.]

Who is doing the research?
My name is Caroline San Miguel. You might see me in the hospital from [insert date] to [insert date] as I collect data for a research project for my PhD studies in the Faculty of Arts and Social Sciences at the University of Technology, Sydney. I will be wearing a badge with my name and research student status so you will be able to identify me. My research focuses on how nursing students learn in the clinical setting and how their supervisors contribute to their learning.

What is the researcher doing?
The hospital has agreed that the researcher may observe and audio record students and clinical facilitators as they are working. She will be making notes about her observations. The main focus of the study is to observe the interactions of students and their facilitators. Sometimes, however, she might be watching nursing students and facilitators when they are near patients, talking to them, or caring for them. Other hospital staff may also be present when she is observing.

If the researcher is observing a student or clinical facilitator, and you are present, she will ask your permission to observe. If you do not want her to observe, you can tell her and she will leave.

All the information collected for the study will be confidential. No real names of patients or other hospital staff or any other details that could identify patients or hospital staff will be recorded.

If you have any questions, you can ask the researcher, Caroline San Miguel, when you see her in the hospital or email her [contact details].

Ethics approval and questions/complaints

This study has also been approved by the Ethics Review Committee [name of Zone] of the [name] Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on [contact details] and quote protocol number xxxx

The conduct of this study at [name of hospital] has also been authorised by the [name of Local Health District]. Any persons with concerns or complaints about the conduct of this study may also contact the Research Governance Officer on [insert telephone number] and quote protocol number [insert local protocol number]

This study has also been approved by the University of Technology, Sydney Human Research Ethics Committee (approval ref. no.). If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer [contact details]. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix 6: information for patients

Research project: Educating nursing students from diverse backgrounds: the clinical experience

Who is doing this project?
My name is Caroline San Miguel. You might see me in the hospital from [insert date] to [insert date] as I collect data for a research project for my PhD studies in the Faculty of Arts and Social Sciences at the University of Technology, Sydney. I will be wearing a badge with my name and research student status so you will be able to identify me. My research, focuses on how nursing students learn in the clinical setting and how their supervisors contribute to their learning.

What is the researcher doing?
The researcher (Caroline San Miguel) will be observing students and supervisors as they are working. She will be making notes about her observations. The main focus of the study is to observe the interactions of students and their supervisors. Sometimes, however, the researcher might be watching nursing students and supervisors when they are near patients, talking to them, or caring for them. Sometimes, the researcher will also be audio recording what students and supervisors say. However, the researcher will not audio record when patients are present.

If the researcher is observing a student or supervisor and you are present, the researcher will ask you for your permission to observe. If you do not want her to observe when you are present, you can tell her and she will leave. Your decision to do so will not affect your current or any future treatment at the hospital. You can also tell the nurse looking after you if you do not want the researcher to observe when you are present.

All the information the researcher collects for the study will be confidential. The researcher will not write down the real names of patients or any other details that could identify patients.

If you would like to ask the researcher any questions, she will be happy to answer them.

Ethics approval and questions/complaints

This study has also been approved by the Ethics Review Committee [name of zone] of the [name] Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on [contact details] and quote protocol number xxxx

The conduct of this study at [name of hospital] has also been authorised by the [name of Local Health District]. Any persons with concerns or complaints about the conduct of this study may also contact the Research Governance Officer on [insert telephone number] and quote protocol number [insert local protocol number]

This study has also been approved by the University of Technology, Sydney Human Research Ethics Committee (approval ref. no.). If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer [contact details]. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix 7: student consent form

I, _____ [PRINT NAME], agree to participate in the research project titled, *Educating nursing students from diverse backgrounds: the clinical experience* **[insert HREC approval number],** conducted by Caroline San Miguel [contact details] from the University of Technology for her PhD degree. This research is conducted under the supervision of Dr Ross Forman [contact details].

1. I understand that the purpose of this research is to explore:
how clinical facilitators talk and interact with students to help them learn
what role language and culture play in those interactions
what students and clinical facilitators think about learning in clinical placement

2. I have read and understood the information sheet and had a chance to ask Caroline San Miguel any questions

3. I understand that the researcher will observe me during my clinical placement and make notes about things she observes. I understand she may also audio record me. I understand that I can ask her not to record if I do not want her to. I understand that the recordings will be transcribed so she can analyse the language used and that transcripts may be used in publications and presentations but that my identity will be kept private and confidential.

4. I understand that the researcher also wants to collect a copy of my Clinical Assessment Form at the end of the clinical block. I understand that my name and student number will be removed from the copy the researcher keeps.

5. I understand that I will also be invited to talk to the researcher in an interview after the clinical placement block to discuss my clinical experiences. I understand that this interview would take no more than an hour and would be held on campus at UTS.

6. I understand that I do not have to be in this research project. My participation is voluntary and will not affect my clinical assessment or my academic grades. If I agree and change my mind before the researcher has finished collecting data, I can tell the researcher or my clinical facilitator that I no longer want to be part of the research project.

7. I understand that I can contact the researcher or her supervisor at any time for more information. (All phone numbers and emails are above.)

Please tick the data you are happy for the researcher to collect

☐Consent to observation and field notes during my clinical placement
☐Consent to audio recording some of the talk between me, my facilitator and other students
☐Consent to audio recording conversations I might have with the researcher during my clinical placement

ALSO

☐I am happy to meet the researcher for an interview after my clinical placement. I understand that this interview will be audio recorded but my comments and identity will be kept confidential.

☐I would like to be sent a clearly written summary of the main findings when the researcher has completed her research

Name (participant) _____

Signature (participant) _____ ____/____/____

Name (witness) _____

Signature (witness) _____ ____/____/____

Information about you

What is your first language? _____

Do you have a second language? _____

Are you an:

☐International student

☐Local student

Email address (if you would like a summary of the findings)

_____@_____

Appendix 8: clinical facilitator consent form

I _____[PRINT NAME], agree to participate in the research project titled, *Educating nursing students from diverse backgrounds*: *the clinical experience* [UTS HREC REF NO.xxxx] conducted by Caroline San Miguel [contact details] from the University of Technology, Sydney for her PhD degree, under the supervision of Dr Ross Forman [contact details].

I understand that the purpose of this study is to investigate student learning and supervision practices during clinical placement.

I have read and understood the information sheet about the research and had the opportunity to ask Caroline San Miguel any questions.

I understand that I have been asked to participate in this study because of my role as a clinical facilitator. I understand that the researcher will 'shadow' me during a first year student clinical placement block for approximately two weeks at one of the hospital sites where I am working as a clinical facilitator with students from the University [name]. I understand the researcher will make field notes about her observations and may make audio recordings of my interactions with students. I also understand that the researcher may talk to me about student learning and that she may record some of these conversations. I understand that I can ask her not to record if I do not want her to.

I understand that the audio recordings will be transcribed but that all notes and transcriptions will be de-identified and pseudonyms will be used for names of people and places to keep all data confidential. I also understand that the researcher will invite me to attend two interviews after the clinical placement.

I understand that this study is voluntary and that participation or non- participation will not affect my employment at the University [name], in any way. I understand that I can withdraw any time before data collection is completed by letting the researcher or her supervisor know that I wish to withdraw.

I know that I can contact the researcher at any time if I have any questions about the research. I can also contact the research supervisor if I have any questions or concerns about the research.

Name (participant) _____

Signature (participant) _____ ___/___/___

Name (witness) _____

Signature (witness) _____ ____/___/___

References

Ajjawi, R., Rees, C., & Monrouxe, L. V. 2015, 'Learning clinical skills during bedside teaching encounters in general practice: a video-observational study with insights from activity theory', *Journal of Workplace Learning*, vol. 27, no. 4, pp. 298-314.

Allen, D. 2010, 'Fieldwork and participant observation', in I. Bourgeault, R. Dingwall & R. de Vries (eds), *The SAGE handbook of qualitative methods in health research*, SAGE, Los Angeles, pp. 353-372.

ACSQHC – see Australian Commission on Safety and Quality in Healthcare

Australian Commission on Safety and Quality in Healthcare 2012, *Safety and quality improvement guide standard 6: clinical handover*, ACSQHC Sydney, viewed 22 May, <http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf>.

Australian Education International, 2016, *Research snapshot: international student numbers 2015*, Department of Education and Training, Australian Government, viewed 8 February 2017, https://internationaleducation.gov.au/Pages/default.aspx>.

Australian Nursing and Midwifery Accreditation Council 2012, *Registered nurse accreditation standards 2012*, ANMAC, Canberra.

ANMAC – see Australian Nursing and Midwifery Accreditation Council

Baynham, M. 2006, 'Agency and contingency in the language learning of refugees and asylum seekers', *Linguistics and Education*, vol. 17, no. 1, pp. 24-39.

Billett, S. 2001 'Learning through work: workplace affordances and individual engagement', *Journal of Workplace Learning* vol. 13, no. 5, pp. 209-14.

Billett, S. 2011, 'Integrating experiences in workplace and university settings: a conceptual perspective', in S. Billett & A. Henderson (eds), *Developing learning professionals, professional and practice-based learning 7*, Springer, London, pp. 21-40.

Billett, S. 2015, 'Readiness and learning in health care education', *The Clinical Teacher,* vol. 12, pp. 367-372.

Bolderston, A., Palmer, C., Flanagan, W. & McParland, N. 2008, 'The experiences of English as second language radiation therapy students in the undergraduate clinical

program: perceptions of staff and students', *Radiography*, vol. 14, no. 3, pp. 216-225.

Bosher, S. 2010, 'English for nursing: developing discipline-specific materials', in N. Harwood (ed.), *Materials in ELT: theory and practice*, Cambridge University Press, Cambridge, pp. 346-372.

Bosher, S. & Smalkoski, K. 2002, 'From needs analysis to curriculum development: designing a course in health-care communication for immigrant students in the USA', *English for Specific Purposes*, vol. 21, no. 1, pp. 59-79.

Boud, D., Keogh, R. & Walker, D. (eds) 1985, *Reflection: turning experience into learning*, Kogan Page, London.

Boughton, M.A., Halliday, L.E. & Brown, L. 2010, 'A tailored program of support for culturally and linguistically diverse (CALD) nursing students in a graduate entry Masters of Nursing course: a qualitative evaluation of outcomes', *Nurse Education in Practice*, vol. 10, no. 6, pp. 355-360.

Bourgeois, S., Drayton, N. & Brown, A.M. 2011, 'An innovative model of supportive clinical teaching and learning for undergraduate nursing students: the cluster model', *Nurse Education in Practice*, vol. 11, no. 2, pp. 114-118.

Brammer, J.D. 2006, 'RN as gatekeeper: student understanding of the RN buddy role in clinical practice experience', *Nurse Education in Practice*, vol. 6, no. 6, pp. 389-396.

Bray, L. & Nettleton, P. 2007, 'Assessor or mentor? Role confusion in professional education', *Nurse Education Today*, vol. 27, no. 8, pp. 848-855.

Brown, P. & Levinson, S. 1987, *Some universals in language usage*, Cambridge University Press, Cambridge.

Brown, V.M. 2005, 'Culturally and linguistically diverse nursing student education: a grounded theory study', PhD thesis, Curtin University of Technology, Western Australia.

Button, D., Kelton, M., Wotton, K. & Gigger, S. 2008, 'The clinical communication program: an innovation in clinical learning for nursing students', *Work Integrated Learning: Transforming Futures, WACE Asia Pacific conference 2008*, Australian Collaborative Education Network, Sydney, pp. 74-80.

Cameron, D. 2001, *Working with spoken discourse*, Sage, London.

Cameron, R. 1998, 'A language-focused needs analysis for ESL-speaking nursing students in class and clinic', *Foreign Language Annals*, vol. 31, no. 2, pp. 203-218.

Candlin, C.N. 2000, 'Reinventing the patient/client: new challenges to healthcare communication', paper presented at the Cardiff Lecture, Health Communication Research Centre, Cardiff University.

Cant, R.P. & Cooper, S.J. 2011, 'The benefits of debriefing as formative feedback in nurse education', *Australian Journal of Advanced Nursing*, vol. 29, no. 1, pp. 37-47.

Cherry, B. 2002, 'Responding to consequences of diversity in nursing education', *Journal of Professional Nursing*, vol. 18, no. 5, pp. 249-250.

Chiang, V. & Crickmore, B.L. 2009, 'Improving English proficiency of post-graduate international nursing students seeking further qualifications and continuing education in foreign countries', *The Journal of Continuing Education in Nursing*, vol. 40, no. 7, pp. 329-336.

Chur-Hansen, A. & Vernon-Roberts, J. 1998, 'Clinical teachers' perceptions of medical students' English language proficiency', *Medical Education*, vol. 32, no. 4, pp. 351-356.

Clarke, A. 2003, 'On being an object of research: reflections from a professional perspective', *Applied Linguistics*, vol. 24, no. 3, pp. 374-385.

Cleary, M., Horsfall, J., Happell, B. & Hunt, G.E. 2013, 'Reflective components in undergraduate mental health nursing curricula: some issues for consideration', *Issues in Mental Health Nursing*, vol. 34, no. 2, pp. 69-74.

Cohen, L., Manion, L. & Morrison, K. 2000, *Research methods in education*, Routledge, London.

Collins, G. 2014, 'Using simulation to develop handover skills', *Nursing Times,* vol. 110, no. 8, pp. 12-14.

Conn, J.J, Lake, F.R., McColl, G.J., Bilszta, J.L. & Woodward-Kron, R. 2012, 'Clinical teaching and learning: from theory and research to application', *Medical Journal of Australia*, vol. 196, no. 8, p. 527.

Cope, B. & Kalantzis, M. 1995, 'The "how" of a pedagogy of multiliteracies', *Occasional paper No. 1.,* NLLIA Centre for Workplace Communication and Culture, University of Technology Sydney.

Cope, P., Cuthbertson, P. & Stoddart, B. 2000, 'Situated learning in the practice placement', *Journal of Advanced Nursing*, vol. 31, no. 4, pp. 850-856.

Coupland, J. (ed.) 2000, *Small talk*, Longman, London.

Couser, G. 2007, 'Twelve tips for developing training programs for international medical graduates', *Medical Teacher*, vol. 29, no. 5, pp. 427-30.

Craven, E. 2012, 'The quest for IELTS band 7.0: investigating English language proficiency development of international students at an Australian university', *IELTS research reports*, vol. 13, viewed 10 December 2015, <http://www.ielts.org/researchers/research/volume_13.aspx>.

Crawford, T. & Candlin, S. 2013, 'Investigating the language needs of culturally and linguistically diverse nursing students to assist their completion of the bachelor of nursing programme to become safe and effective practitioners', *Nurse Education Today*, vol. 33, no. 8, pp. 796-801.

Crawford, T., Roger, P. & Candlin, S. 2017, 'Tracing the discursive development of rapport in intercultural nurse-patient interactions', *International Journal of Applied Linguistics,* DOI: 10.1111/ijal.1216, viewed 26 June 2017, <http://onlinelibrary.wiley.com.ezproxy.lib.uts.edu.au/doi/10.1111/ijal.12166/full>

Crawford, T., Roger, P. & Candlin, S. 2017a, 'The intercultural consequences of 'empowering discourse' in intercultural patient education', *Patient Education and Counseling,* vol. 100, no. 3, pp. 495-500

Creese, A. 2005, 'Mediating allegations of racism in a multiethnic London school: what speech communities and communities of practice can tell us about discourse and power', in D. Barton & K. Tusting (eds), *Beyond communities of practice: language, power, and social context*, Cambridge University Press, Cambridge, pp. 55-76.

Creswell, J.W. 2007, *Qualitative inquiry and research design: choosing among five approaches*, 2nd edn, Sage, Thousand Oaks, California.

Cross, D. & Smalldridge, A. 2011, 'Improving written and verbal communication skills for international medical graduates: a linguistic and medical approach', *Medical Teacher*, vol. 33, no. 7, pp. e364-e367.

Cullen, R. 2002, 'Supportive teacher talk: the importance of the F-move', *ELT Journal*, vol. 56, no. 2, pp. 117-27.

Dahm, M.R. 2011, 'Exploring perception and use of everyday language and medical terminology among international medical graduates in a medical ESP course in Australia', *English for Specific Purposes*, vol. 30, no. 3, pp. 186-197.

Davies, E. 1995, 'Reflective practice: a focus for caring', *Journal of Nursing Education*, vol. 34, no. 4, pp. 167-174.

De Haes, J.C.J.M., Oort, F.J. & Hulsman, R.L. 2005, 'Summative assessment of medical students' communication skills and professional attitudes through observation in clinical practice', *Medical Teacher*, vol. 27, no. 7, pp. 583-589.

Deegan, J. & Simkin, K. 2010, 'Expert to novice: experiences of professional adaptation reported by non-English speaking nurses in Australia', *Australian Journal of Advanced Nursing*, vol. 27, no. 3, pp. 31-37.

Defibaugh, S. 2014, 'Solidarity and alignment in nurse practitioner - patient interactions', *Discourse and Communication*, vol. 8, no. 3, pp. 260-277.

Dewey, J. 1933, *How we think: a restatement of the relation of reflective thinking to the educative process*, D.C. Heath, Lexington.

Dickson, C., Lock, L. & Carey, M. 2007, '"In my country nurses don't ..." Australian undergraduate nurse education and the international culturally and linguistically different student', *18th ISANA International Education Conference*, ISANA International Education Association, The Gap, Queensland, Australia.

Dickson, C., Walker, J. & Bourgeois, S. 2006, 'Facilitating undergraduate nurses' clinical practicum: the lived experience of clinical facilitators', *Nurse Education Today*, vol. 26, no. 5, pp. 416-422.

Dickson, C.L. 2013, 'The nature of learning to nurse through clinical practice experience for international culturally and linguistically different students in Sydney, Australia: an interpretive description, D. Nursing, University of Technology Sydney, Australia.

Donnelly, T.T., McKiel, E. & Hwang, J. 2009, 'Factors influencing the performance of English as an Additional Language nursing students: instructors' perspectives', *Nursing Inquiry*, vol. 16, no. 3, pp. 201-211.

Drew, P. & Heritage, J. 1992, 'Analyzing talk at work: an introduction', in P. Drew & J. Heritage (eds), *Talk at work: interaction in institutional settings*, Cambridge University Press, Cambridge, pp. 3-66.

Duff, P.A. 2003, 'New directions in second language socialization research', *Korean Journal of English Language and Linguistics,* vol. 3, no. 3, pp. 309-339.

Duff, P.A. 2007, 'Second language socialization as sociocultural theory: insights and issues, *Language Teaching*, vol. 40, no. 4, pp. 309–319.

Duff, P.A. 2012, 'Second language socialization', in A. Duranti, E. Ochs & B. Schieffelin (eds), *Handbook of language socialization*, Wiley- Blackwell, Malden, MA, pp. 564-586.

Duff, P.A., Wong, P. & Early, M. 2002, 'Learning language for work and life: the linguistic socialization of immigrant Canadians seeking careers in healthcare', *The Modern Language Journal*, vol. 86, no. 3, pp. 397-422.

Dufrene, C. & Young, A. 2014, 'Successful debriefing—best methods to achieve positive learning outcomes: a literature review', *Nurse Education Today*, vol. 34, no. 3, pp. 372-376.

Dunn, S.V. & Hansford, B. 1997, 'Undergraduate nursing students' perceptions of their clinical learning environment', *Journal of Advanced Nursing*, vol. 25, no. 6, pp. 1299-1306.

Dwyer, P.A. & Hunter Revell, S.M. 2015, 'Preparing students for the emotional challenges of nursing: an integrative review', *Journal of Nursing Education*, vol. 54, no. 1, pp. 7-12.

Edwards, N. & Mercer, N. 1987, *Common knowledge: the development of understanding in the classroom*, Methuen, London.

Eggins, S. 2016, 'As a doctor, you're always learning: discourse strategies senior clinicians use to teach junior clinicians on the job', in H. De Silva Joyce (ed.), *Language at work: analysing language use in work, education, medical and museum contexts*, Cambridge scholars publishing, Newcastle upon Tyne, pp. 166-191.

Eggins, S. & Slade, D. 2012, 'Clinical handover as an interactive event: informational and interactional communication strategies in effective shift-change handovers', *Communication & Medicine*, vol. 9, no. 3, pp. 215-227.

Elder, C., Pill, J., Woodward-Kron, R., McNamara, T., Manias, E., Webb, G. & McColl, G., 2012, 'Health professionals' views of communication: implications for assessing performance on a health-specific English language test', *TESOL Quarterly*, vol. 46, no.2, pp. 409–419.

Erickson, F. 1999, 'Appropriation of voice and presentation of self as a fellow physician: aspects of a discourse of apprenticeship in medicine', in S. Sarangi & C. Roberts (eds), *Talk, work and institutional order: discourse in medical, mediation and management settings*, Mouton de Gruyter, Berlin, pp. 109-143.

Erickson, F. & Schultz, J. 1982, *The counselor as gatekeeper: social and cultural organization of communication in counselling interviews*, Academic Press, New York.

Eyre, J. 2010, 'Finding a voice: supporting ESL nursing students' communication in clinical placement', viewed 7 February 2017, <https://akoaotearoa.ac.nz/ako-hub/ako-aotearoa-central-hub/resources/pages/finding-voice-supporting-esl-nursing-students%E2%80%99-comm>.

Fanning, R.M. & Gaba, D.M. 2007, 'The role of debriefing in simulation-based learning', *Simulation in Healthcare*, vol. 2, no. 2, pp. 115-125.

Ferguson, A. 2010, 'Appraisal in student-supervisor conferencing: a linguistic analysis', *International Journal of Language and Communication Disorders*, vol. 45, no. 2, pp. 215-229.

Fey, M.K., Scrandis, D., Daniels, A., & Haut, C. 2014, 'Learning through debriefing: students' perspectives', *Clinical Simulation in Nursing*, vol. 10, no. 5, pp. e249-e256.

Forman, R. 2005, 'Teaching EFL in Thailand: a bilingual study', PhD thesis, University of Technology Sydney, Australia.

Forman, R. 2008, 'Using notions of scaffolding and intertextuality to understand the bilingual teaching of English in Thailand', *Linguistics and Education*, vol. 19, no. 4, pp. 319-32.

Fuller, A., Hodkinson, H., Hodkinson, P. & Unwin, L. 2005, 'Learning as peripheral participation in communities of practice: a reassessment of key concepts in workplace learning', *British Educational Research Journal*, vol. 31, no. 1, pp. 49-68.

Garcia, J.R. & Cain, K. 2014, 'Decoding and reading comprehension: a meta-analysis to identify which reader and assessment characteristics influence the strength of the relationship in English', *Review of Educational Research*, vol. 84, no. 1, pp. 74-111.

Garling, P. 2008, *Final report of the special commission of inquiry: acute care services in NSW public hospitals*, Sydney, Special Commission of Inquiry, Acute Care in NSW Public Hospitals.

Geertz, C. 1973, *The interpretation of cultures,* Basic books, New York.

Gherardi, S. 2006, *Organizational knowledge: The texture of workplace learning*, Blackwell publishing, Malden, MA USA.

Gibbons, C., Dempster, M. & Moutray, M. 2008, 'Stress and eustress in nursing students', *Journal of Advanced Nursing*, vol. 61, no. 3, pp. 282-290.

Gibbons, P. 1998. 'Classroom talk and the learning of new registers in a second language', *Language and Education*, vol. 12, no. 2, pp. 99-118.

Gibbons, P. 1999, 'Discourse contexts for second language development in the mainstream classroom', Ph.D. thesis, University of Technology Sydney, Australia.

Gibbons, P. 2006, *Bridging discourses in the ESL classroom: students, teachers and researchers*, Continuum, London.

Glew, P.J., Hillege, S.P., Salamonson, Y., Dixon, K., Good, A. & Lombardo, L. 2015, 'Predictive validity of the post-enrolment English language assessment tool for commencing undergraduate nursing students', *Nurse Education Today*, vol. 35, no. 12, pp. 1142–1147.

Goffman, E. 1961, 'Encounters: two studies on the sociology of interaction, Bobbs-Merrill, Oxford.

Goffman, E. 1974, *Frame analysis: an essay on the organization of experience*, Harvard University Press, Cambridge, Massachusetts.

Goffman, E. 1981, *Forms of talk*, University of Pennsylvania Press, Philadelphia.

Grabe, W. 2009, *Reading in a second language: moving from theory to practice*, Cambridge University Press, New York, NY.

Grabe, W. & Stoller, F.L. 2013, 'Reading and language for specific purposes', *The Encyclopedia of Applied Linguistics*, Blackwell Publishing Ltd.

Gregory, L.R. 2016, 'Learning with and from others in clinical practice', PhD thesis, University of Technology Sydney, Australia.

Gregory, L.R., Hopwood, N. & Boud, D. 2014, 'Interprofessional learning at work: what spatial theory can tell us about workplace learning in an acute care ward', *Journal of Interprofessional Care*, vol. 28, no. 3, pp. 200-205.

Greiff, J.L., Graville Bricker, M., Gamaghelyan, P., Tadevosyan, M. & Deng, S., 2015, 'Debriefing in peacemaking and conflict resolution practice: models of emergent learning and practitioner support,' *Reflective Practice*, vol. 16, no. 2, pp. 254-268.

Gulson, K.N. & Symes, C. 2007 'Knowing one's place: space, theory, education', *Critical Studies in Education,* vol. 48, no. 1, pp. 97-110.

Gumperz, J.J. 1999, 'On interactional sociolinguistic method', in S. Sarangi & C. Roberts (eds.), *Talk, work and institutional order: discourse in medical, mediation and management settings*, Mouton, Berlin, pp. 453-471.

Hadi-Tabassum, S. 2006, *Language, space and power: a critical look at bilingual education*, Multilingual Matters, Clevedon, England.

Hak, T. 1999, '"Text" and "con-text": talk bias in studies of health care work', in S. Sarangi & C. Roberts (eds), *Talk, work and institutional order: discourse in medical, mediation and management settings*, Mouton de Gruyter, Berlin, pp. 427-453.

Hall, P., Keely, E., Dojeiji, S., Byszewski, A. & Marks, M. 2004, 'Communication skills, cultural challenges and individual support: challenges of international medical graduates in a Canadian healthcare environment', *Medical Teacher*, vol. 26, no. 2, pp. 120-125.

Hammersley, M. & Atkinson, P. 2007, *Ethnography: principles in practice*, London, 3rd edn, Routledge.

Harvey, T., Robinson, C. & Frohman, R. 2013, 'Preparing culturally and linguistically diverse nursing students for clinical practice in the health care setting', *Journal of Nursing Education*, vol. 52, no. 7, pp. 365-370.

Hawthorne, L., Minas, I.H. & Singh, B. 2004, 'A case study in the globalization of medical education: assisting overseas-born students at the University of Melbourne', *Medical Teacher*, vol. 26, no. 2, pp. 150-159.

Heath, S.B. 1983, *Ways with words: language, life, and work in communities and classrooms*, Cambridge University Press, Cambridge.

Health Workforce Australia 2013, *Australia's health workforce series- nurses in focus*, Health Workforce Australia, Adelaide, South Australia, viewed 8 February 2017, <http://hdl.voced.edu.au/10707/258616>.

Henderson, A., J., Alexander, H., Haywood, A., Stapleton, P., Cooke, M., Patterson, E., Dalton, M. & Creedy, D., K. 2010, 'Promoting and providing expert guidance in work-intensive clinical settings', *Vocations and Learning*, vol. 3, no. 2, pp. 141-156.

Henderson, A. & Tyler, S. 2011, 'Facilitating learning in clinical practice: evaluation of a trial of a supervisor of clinical education role', *Nurse Education in Practice*, vol. 11, pp. 288-292.

Henderson, S., Barker, M. & Mak, A. 2016, 'Strategies used by nurses, academics and students to overcome intercultural communication challenges', *Nurse Education in Practice*, vol. 16, no. 1, pp. 71-78.

Hillege, S.P., Catterall, J., Beale, B.L. & Stewart, L., 2014, 'Discipline matters: embedding academic literacies into an undergraduate nursing program', *Nurse Education in Practice*, vol. 14, no. 6, pp. 686-691.

Hobbs, P. 2004, 'The role of progress notes in the professional socialization of medical residents', *Journal of Pragmatics*, vol. 36, no. 9, pp. 1579–1607.

Hobbs, P. 2007, 'The communicative functions of the hospital medical chart', in R.A. Iedema (ed.), *The discourse of hospital communication: tracing complexities in contemporary health care organizations*, Palgrave Macmillan, Basingstoke, Hampshire, pp. 39-66.

Holmes, J. 2003, 'Small talk at work: potential problems for workers with an intellectual disability,' *Research on Language and Social Interaction,* vol. 36, no. 1, pp. 65-84.

Holmes, J. & Major, G. 2002, 'Nurses communicating on the ward: the human face of hospitals', *Kai Tiaki, Nursing New Zealand*, vol. 8, no. 11, pp. 14-16.

Holmes, J. & Major, G. 2003, 'Talking to patients: the complexity of communication on the ward. ', *Vision: A Journal of Nursing*, vol. 11, no. 17, pp. 4-9.

Holmlund, K., Lindgren, B. & Athlin, E. 2010, 'Group supervision for nursing students during their clinical placements: its content and meaning', *Journal of Nursing Management*, vol. 18, no. 6, pp. 678-688.

Hopwood, N. 2014, 'Four essential dimensions of workplace learning, *Journal of Workplace Learning*, vol. 26, no. 6/7, pp.349-363.

Horsfall, J. 1990, 'Clinical placement: prebriefing and debriefing as teaching strategies', *The Australian Journal of Advanced Nursing*, vol. 8, no. 1, pp. 3-7.

Hsu, L.L. 2007, 'Conducting clinical post-conference in clinical teaching: a qualitative study', *Journal of Clinical Nursing*, vol. 16, no. 8, pp. 1525-1533.

Hsu, W. 2013, 'Bridging the vocabulary gap for EFL medical undergraduates: the establishment of a medical word list', *Language Teaching Research*, vol. 17, no. 4, pp. 454-484.

Hussin, V. 2002, 'An ESP program for students of nursing', in T. Orr (ed.), *English for Specific Purposes*, Alexandria, VA, TESOL, pp. 25-40.

Hussin, V. 2009, 'Facilitating success for ESL nursing students in the clinical setting: models of learning support', in S. D. Bosher & M.D. Pharris (eds), *Transforming nursing education: the culturally inclusive environment*, Springer, New York, NY, pp. 363-386.

Hutton, A. 2002, 'The private adolescent: privacy needs of adolescents in hospitals', *Journal of Pediatric Nursing*, vol. 17, no. 1, pp. 67-72.

Hymes, D. 1972, 'The ethnography of speaking', in T.G.W. Sturtevant (ed.), *Anthropology and human behavior,* Anthropological Society of Washington, Washington, DC, pp. 13–53.

Hymes, D. 1974, *Foundations in sociolinguistics: an ethnographic approach*, University of Pennsylvania Press, Philadelphia.

Iedema, R.A. 2007, 'Communicating hospital work', in R.A. Iedema (ed.), *The discourse of hospital communication*, Palgrave-Macmillan, Basingstoke, Hampshire, pp. 1-17.

Iedema, R., Brownhill, S., Haines, M., Lancashire, B., Shaw, T. & Street, J. 2010, ''Hands on, hands off': a model of clinical supervision that recognises trainees' need for support and independence', *Australian Health Review*, vol. 34, pp. 286-291.

Iedema, R., Long, D., Carroll, K., Stenglin, M. & Braithwaite, J. 2006, 'Corridor work: how liminal space becomes a resource for handling complexity in health care', *Proceedings of the Australian-Pacific Researchers in Organization Studies Conference,* Asia-Pacific Researchers in Organization Studies, pp. 238-247.

Iedema, R., Piper, D. & Manidis, M. 2015, 'Introduction: communicating for quality and safety', in R. Iedema, D. Piper & M. Manidis (eds), *Communicating quality and safety in health care',* Melbourne, Cambridge University Press, pp. 2-16.

Jack, K. & Wibberley, C. 2014, 'The meaning of emotion work to student nurses: a Heideggerian analysis', *International Journal of Nursing Studies*, vol. 51, no. 6, pp. 900-907.

Jenkins, T. 2009, 'A descriptive study to explore the adaptation of culturally and linguistically (CaLD) nurses to the nursing workforce in South Australia: the first three months', Master of Nursing, University of South Australia.

Jeong, S.Y.S., Hickey, N., Levett-Jones, T., Pitt, V., Hoffman, K., Norton, C.A. & Ohr, S.O. 2011, 'Understanding and enhancing the learning experiences of culturally and linguistically diverse nursing students in an Australian bachelor of nursing program', *Nurse Education Today*, vol. 31, no. 3, pp. 238-244.

Jeong, S.Y.S. 2016, 'Culturally and linguistically diverse healthcare students can find integration into clinical placements', *Evidence Based Nursing*, vol. 19, no. 2, pp. 61-61.

Jette, D.U., Bertoni, A., Coots, R., Johnson, H., McLaughlin, C. & Weisbach, C. 2007, 'Clinical instructors' perceptions of behaviors that comprise entry-level clinical performance in physical therapist students: a qualitative study', *Physical Therapy*, vol. 87, no. 7, pp. 833-843.

Khawaja, N. G., Chan, S., & Stein, G. (2017). The relationship between second language anxiety and international nursing students' stress. *Journal of International Students*, vol. *7*, no. 3, pp. 601-620.

Kilminster, S.M. & Jolly, B.C. 2000, 'Effective supervision in clinical practice settings: a literature review', *Medical Education*, vol. 34, no. 10, pp. 827-840.

Klisch, M.L. 2000, 'Retention strategies for ESL nursing students', *The Journal of Multicultural Nursing and Health*, vol. 6, no. 1, pp. 21-28.

Kossman, S.P. 2009, 'The power of nurse educators: welcoming and unwelcoming behaviors', in S. Bosher Dandridge & M. Dexheimer Pharris (eds), *Transforming Nursing Education: the culturally inclusive environment*, Springer, New York, pp. 27-60.

Kostiuk, S. 2015, 'Can learning the ISBARR framework help to address nursing students' perceived anxiety and confidence levels associated with handover reports?', *Journal of Nursing Education*, vol. 54, no. 10, pp. 583-587.

Labov, W. 1972, *Sociolinguistic patterns*, Pennsylvania University press, Philadelphia.

Ladyshewsky, R. 1996, 'Cross cultural clinical supervision: the impact on culture of teaching and learning', *Different Approaches; Theory and Practice in Higher Education*, Proceedings HERDSA conference 1996, Perth, Western Australia, 8-12 July.

Lantolf, J.P. 2007, 'Sociocultural theory: a unified approach to L2 learning and teaching', in C. Davidson & J. Cummins (eds) *International handbook of English language teaching,* Springer*,* New York*,* pp. 693-700.

Lather, P. 1991, *Getting smart: feminist research and pedagogy with/in the postmodern*, Routledge, New York.

Lave, J. 1988, *Cognition in practice: mind, mathematics and culture in everyday life*, Cambridge University Press, Cambridge.

Lave, J. & Wenger, E. 1991, *Situated learning: legitimate peripheral participation*, Cambridge University Press, Cambridge.

Lefebvre, H. 1991, *The production of space*, Blackwell, Oxford.

Le Maistre, C., Boudreau, S. & Paré, A. 2006, 'Mentor or evaluator? Assisting and assessing newcomers to the professions', *Journal of Workplace Learning*, vol. 18, no. 6, pp. 344-354.

Levett-Jones, T. & Bourgeois, S. 2015, *The clinical placement: an essential guide for nursing students*, 3rd edn, Churchill Livingstone, Sydney.

Levett-Jones, T., Lathlean, J., McMillan, M. & Higgins, I. 2007, 'Belongingness: a montage of nursing students' stories of their clinical placement experiences', *Contemporary Nurse*, vol. 24, no. 2, pp. 162-174.

Levinson, S. 1979, 'Activity types and language', *Linguistics*, vol. 17, no. 5-6, pp. 365-400.

Liu, S. 2013, 'Should 4th grade ELL students read aloud or silently? Empirical implications from subsets of data taken from two large databases', *Theory and Practice in Language Studies*, vol. 3, no. 11, pp. 1959-1968.

Liu, W., Manias, E. & Gerdtz, M. 2012 'Medication communication between nurses and patients during nursing handovers on medical wards: a critical ethnographic study', *International Journal of Nursing Studies*, vol. 49, no. 8, pp. 941-952.

Long, D., Iedema, R. & Lee, B.B. 2007, 'Corridor conversations: clinical communication in casual spaces', in R. Iedema (eds.), *Discourses of hospital communication: tracing complexities in contemporary health organizations*, Palgrave Macmillan, Basingstoke, Hampshire, pp. 182-200.

Lopes, A., Boyd, P., Andrew, N. & Pereira, F. 2014, 'The research-teaching nexus in nurse and teacher education: contributions of an ecological approach to academic identities in professional fields', *Higher Education*, vol. 68, no. 2, pp. 167-183.

Lu, H. & Malthus, C. 2012, 'Experiences of clinical tutors with English as an additional language (EAL) students', *Nursing Praxis in New Zealand*, vol. 28, no. 3, pp. 4-12.

Mackenzie, L. 2002, 'Briefing and debriefing of student fieldwork experiences: exploring concerns and reflecting on practice', *Australian Occupational Therapy Journal*, vol. 49, no. 2, pp. 82-92.

Major, G. & Holmes, J. 2008, 'How do nurses describe health care procedures? Analysing nurse-patient interaction in a hospital ward', *Australian Journal of Advanced Nursing*, vol. 25, no. 4, pp. 58-70.

Malau-Aduli, B.S. 2011, 'Exploring the experiences and coping strategies of international medical students', *BMC Medical Education*, vol. 11, no. 40, pp. 1-12.

Malone, L., Anderson, J. & Manning, J. 2016, 'Student participation in clinical handover–an integrative review', *Journal of Clinical Nursing,* vol. 25, no. 5-6, pp. 575-582.

Malthus, C., Holmes, J. & Major, G. 2005, 'Completing the circle: research-based classroom practice with EAL nursing students', *New Zealand Studies in Applied Linguistics*, vol. 11, no. 1, pp. 65-90.

Malthus, C. & Lu, H. 2012, '"Not a mission impossible": the perceptions of successful graduates on the development of spoken English for the workplace', *Journal of Asian Pacific Communication*, vol. 22, no. 1, pp. 120-139.

Malu, K.F. & Figlear, M.R. 1998, 'Enhancing the language development of immigrant ESL nursing students: a case study with recommendations for action', *Nurse Educator*, vol. 23, no. 2, pp. 43-46.

Mann, K., Gordon, J. & MacLeod, A. 2009, 'Reflection and reflective practice in health professions' education: a systematic review', *Advances in Health Sciences Education*, vol. 14, no. 4, pp. 595-621.

Manning, A., Cronin, P., Monaghan, A. & Rawling-Anderson, K. 2009, 'Supporting students in practice: an exploration of reflective groups as a means of support', *Nurse Education in Practice*, vol. 9, no. 3, pp. 176-183.

Mattila, L.R., Pitkäjärvi, M. & Eriksson, E., 2010, 'International student nurses' experiences of clinical practice in the Finnish health care system', *Nurse Education in Practice*, vol. 10, no. 3, pp. 153-157.

McCarthy, B. & Murphy, S. 2008, 'Assessing undergraduate nursing students in clinical practice: do preceptors use assessment strategies?', *Nurse Education Today*, vol. 28, no. 3, pp. 301-313.

Megel, M.E., Nelson, A.E., Black, J., Vogel, J. & Uphoff, M. 2013, 'A comparison of student and faculty perceptions of clinical post-conference learning environment', *Nurse Education Today*, vol. 33, no. 5, pp. 525-529.

Mehan, H. 1979, *Learning lessons: social organisation in the classroom*, Harvard University Press, Cambridge, Massachusetts.

Mercer, N. 1995, *The guided construction of knowledge: talk amongst teachers and learners*, Multilingual Matters Ltd, Clevedon.

Mikkonen, K., Elo, S., Kuivila, H-M., Tuomikoski, A-M. & Kääriäinen, M. 2016a, 'Culturally and linguistically diverse healthcare students' experiences of learning in a clinical

environment: a systematic review of qualitative studies', *International Journal of Nursing Studies*, vol. 54, pp. 173–187.

Mikkonen, K., Elo, S., Tuomikoski, A-M. & Kääriäinen, M. 2016b, 'Mentor experiences of international healthcare students' learning in a clinical environment: a systematic review', *Nurse Education Today*, vol. 40, pp. 87-94.

Molodysky, E. 2007, 'Clinical teacher training: maximising the 'ad hoc' teaching encounter', *Australian Family Physician*, vol. 36, no. 12, pp. 1044-1046.

Morrison, J., Clement, T., Brown, J. & Nestel, D. 2014, *Ad hoc supervisory encounters between GP-supervisors and GP-registrars: enhancing quality and effectiveness,* Warrnambool, Southern GP Training.

Müller, A., Arbon, P. & Gregoric, C. 2015, 'A school-based approach to developing the English proficiency of EAL university students', *Journal of Academic Language and Learning*, vol. 9, no. 2, pp. A63-A78.

Mullock, B., 4. 2008, 'On reading aloud in the TESOL classroom', *TESOL in Context*, vol. 17, no. 2, pp. 4-9.

Nash, R.E. 2007, 'Collaboration in clinical education: development, implementation and evaluation of an innovative model of clinical education for undergraduate nursing students', PhD thesis, Queensland University of Technology.

New South Wales Health 2016, *eHealth Strategy for NSW Health 2016-2026: a digitally enabled and integrated health system delivering patient-centred health experiences and quality health outcomes*, NSW Government, Sydney, viewed 31 October 2016, http://www.health.nsw.gov.au/eHealth/Documents/eHealth-Strategy-for-NSW-Health-2016-2026.pdf>.

Newton, J., M. 2011, 'Reflective learning groups for student nurses', in S. Billett & A. Henderson (eds), *Developing learning professionals: integrating experiences in university and practice settings*, Springer Dordrecht, Netherlands, pp. 119-130.

Newton, J.M., Henderson, A., Jolly, B. & Greaves, J. 2015, 'A contemporary examination of workplace learning culture: an ethnomethodology study', *Nurse Education Today,* vol. 35, pp. 91-96.

Nicolini, D. 2012, *Practice theory, work, and organization: an introduction*, Oxford University Press, Oxford.

NMBA – see Nursing and Midwifery Board of Australia

Norton, B. & Toohey, K. 2001, 'Changing perspectives on good language learners', *TESOL Quarterly*, vol. 35, no. 2, pp. 307-322.

Nursing and Midwifery Board of Australia 2006, *National competency standards for the registered nurse*, NMBA, viewed 8 February 2017, <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>.

Nursing and Midwifery Board of Australia 2011, *English language skills registration standard*, NMBA, viewed September 8, 2017, <http://www.nursingmidwiferyboard.gov.au/News/2011-08-29-New-English-Language-Skills-Registration-Standard.aspx>.

Nursing and Midwifery Board of Australia 2016, *Registered Nurse Standards for Practice*, NMBA, viewed 8 February 2017, <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>.

Ochs, E. 1988, *Culture and language development: language acquisition and language socialization in a Samoan village*, Cambridge University Press, Cambridge.

O'Neill, F. 2011, 'From language classroom to clinical context: the role of language and culture in communication for nurses using English as a second language: a thematic analysis', *International Journal of Nursing Studies*, vol. 48, no. 9, pp. 1120-1128.

Opie, R. 2016, 'Nurses 'failed to check patient's report' before traumatic hospital death', *ABC NEWS*, viewed 28 October 2016, <http://www.abc.net.au/news/2016-10-28/stephen-herczeg-inquest-qeh-nurse-'failure-to-check-report'/7976662?appref%3Dflagship_ipad>.

O'Reilly, S.L. & Milner, J. 2015, 'Supporting culturally and linguistically diverse students during clinical placement: strategies from both sides of the table', *BMC Medical Education*, vol. 15, p. 175.

Organisation for Economic Co-operation and Development 2015, 'Indicator C4 who studies abroad and where?', in *Education at a glance 2015: OECD indicators*, OECD Publishing, Paris, viewed 5 March 2017, http://www.oecd-ilibrary.org/education/education-at-a-glance-2015/indicator-c4-who-studies-abroad-and-where_eag-2015-27-en>.

Oxford, R., L. 2003, 'Toward a more systematic model of L2 learner autonomy', in D. Palfreyman & R.C. Smith (eds), *Learner autonomy across cultures: language education perspectives*, Palgrave Macmillan, New York, pp. 75-91.

Parks, S. 2000, 'Professional writing and the role of incidental collaboration: evidence from a medical setting', *Journal of Second Language Writing*, vol. 9, no. 2, pp. 101-122.

Parks, S. 2001, 'Moving from school to the workplace: disciplinary innovation, border crossings, and the reshaping of a written genre', *Applied Linguistics*, vol. 22, no. 4, pp. 405-438.

Parks, S. & Maguire, M.H. 1999, 'Coping with on-the-job writing in ESL: a constructivist-semiotic perspective', *Language Learning*, vol. 49, no. 1, pp. 143-175.

Pearce, C. 2003, 'Corridor teaching: 'have you got a minute...?'', *Australian Family Physician*, vol. 32, no. 9, pp. 745-747.

Peng, J.E. 2012, 'Towards an ecological understanding of willingness to communicate in EFL classrooms in China', *System*, vol. 40, no. 2, pp. 203-213.

Pennycook, A. (2010). *Language as a local practice*, Routledge, London

Peters, M. & ten Cate, O. 2014, 'Bedside teaching in medical education: a literature review', *Perspectives on Medical Education*, vol. 3, no. 2, pp. 76-88.

Pilotto, L., Duncan, G.F. & Anderson-Wurf, J. 2007, 'Issues for clinicians training international medical graduates: a systematic review', *Medical Journal of Australia*, vol. 187, no. 4, pp. 225-22 8.

Pitkäjärvi, M., Eriksson, E. & Pitkälä, K. 2012, 'The diversity issue revisited: international students in clinical environment', *ISRN nursing*, pp. 1-6, viewed January 18 2017, <http://dx.doi.org/10.5402/2012/294138>.

Poehner, M.E. & Lantolf, J.P. 2005, 'Dynamic assessment in the language classroom', *Language Teaching Research*, vol. 9, no. 3, pp. 233-65.

Pomerantz, A.M., Ende, J. & Erickson, F. 1995, 'Precepting conversations in a general medical clinic', in G.H. Morris & R.J. Chenail (eds), *The talk of the clinic: explorations in the analysis of medical and therapeutic discourse*, Lawrence Erlbaum Associates, New Jersey, pp. 151-69.

Preston, B. 2009, 'The Australian nurse and midwifery workforce: issues, developments and the future', *Collegian*, vol. 16, no. 1, pp. 25-34.

Qureshi, Z. 2014, 'Back to the bedside: the role of bedside teaching in the modern era.', *Perspectives on Medical Education*, vol. 3, no. 2, pp. 69-72.

Qureshi, Z. & Maxwell, S. 2012, 'Has bedside teaching had its day?', *Advances in Health Sciences Education*, vol. 17, no. 2, pp. 301-4.

Reeves, S., Kuper, A. & Hodges, B.D. 2008, 'Qualitative research methodologies: ethnography', *BMJ: British Medical Journal*, vol. 337, pp. 512-4.

Rizan, C., Elsey, C., Lemon, T., Grant, A. & Monrouxe, L.V. 2014, 'Feedback in action within bedside teaching encounters: a video ethnographic study', *Medical Education*, vol. 48, no. 9, pp. 902-920.

Roberts, C. 1997, 'The politics of transcription; transcribing talk: issues of representation', *TESOL Quarterly*, vol. 31, no. 1, pp. 167-172.

Roberts, C. 2006a, 'Figures in a landscape: some methodological issues in adult ESOL research', *Linguistics and Education*, vol. 17, pp. 6-23.

Roberts, C. 2006b 'Transcription conventions for the special issue', *Linguistics and Education*, vol. 17, no. 1, p. 106.

Roberts, C. 2010, 'Language socialization in the workplace', *Annual Review of Applied Linguistics*, vol. 30, pp. 211-227.

Roberts, C. & Sarangi, S. 1999, 'Hybridity in gatekeeping discourse: issues of practical relevance for the researcher', in S. Sarangi & C. Roberts (eds.), *Talk, work and institutional order: discourse in medical, mediation and management settings*, Mouton, Berlin, pp. 473–503.

Roberts, C. & Sarangi, S. 2003, 'Uptake of discourse research in interprofessional settings: reporting from medical consultancy', *Applied Linguistics*, vol. 24, no. 3, pp. 338-359.

Roberts, C. & Sarangi, S. 2005, 'Theme-oriented discourse analysis of medical encounters.', *Medical Education*, vol. 39, no. 6, pp. 632-640.

Rogan, F., San Miguel, C., Brown, D. & Kilstoff, K. 2006, 'You find yourself: perceptions of nursing students from non-English speaking backgrounds of the effect of an intensive language support program on their oral communication skills', *Contemporary Nurse*, vol. 23, no. 1, pp. 72-87.

Rogoff, B. & Lave, J. (eds) 1984, *Everyday Cognition: its development in in social context*, Harvard University Press, Cambridge, MA.

Rossignol, M. 2000, 'Verbal and cognitive activities between and among students and faculty in clinical conferences', *Journal of Nursing Education*, vol. 39, no. 6, pp. 245-50.

Rowe, M.B. 1986, 'Wait time: slowing down may be a way of speeding up!', *Journal of Teacher Education*, vol. 37, no. 1, pp. 43-50.

Salamonson, Y., Andrew, S., Clauson, J., Cleary, M., Jackson, D. & Jacobs, S. 2011, 'Linguistic diversity as sociodemographic predictor of nursing program progression and completion', *Contemporary Nurse*, vol. 38, no. 1-2, pp. 84-93.

Salamonson, Y., Everett, B., Halcomb, E., Hutchinson, M., Jackson, D., Mannix, J., Peters, K. & Weaver, R. 2015, 'Unravelling the complexities of nursing students' feedback on the clinical learning environment: a mixed methods approach', *Nurse Education Today*, vol. 35, no. 1, pp. 206-211.

Salamonson, Y., Ramjan, L., Lombardo, L., Lanser, L.H., Fernandez, R. & Griffiths, R. 2012, 'Diversity and demographic heterogeneity of Australian nursing students: a closer look', *International Nursing Review*, vol. 59, no. 1, pp. 59-65.

San Miguel[3], C. & Rogan, F. 2009, 'A good beginning: the long-term effects of a clinical communication programme', *Contemporary Nurse*, vol. 33, no. 2, pp. 179-190.

San Miguel, C. & Rogan, F. 2012, 'Clinical expectations: what facilitators expect from ESL students on clinical placement', *Nurse Education in Practice*, vol. 12, no. 2, pp. 115-119.

San Miguel, C. & Rogan, F. 2015, 'Assessing students' English language proficiency during clinical placement: a qualitative evaluation of a language framework', *Nurse Education Today*, vol. 35, no. 6, pp. 771-776.

San Miguel, C., Rogan, F., Brown, D. & Kilstoff, K. 2006, 'Clinically speaking: a communication skills program for students from non-English speaking backgrounds', *Nurse Education in Practice*, vol. 6, no. 5, pp. 268-274.

San Miguel, C., Townsend, L. & Waters, C. 2013, 'Redesigning nursing tutorials for ESL students: a pilot study', *Contemporary Nurse,* vol. 44, no. 1, pp. 21-31.

[3] Previously, I published under the name Caroline San Miguel. All references to work by San Miguel in this thesis are my previous publications.

Sanderson, H. & Lea, J. 2012, 'Implementation of the clinical facilitation model within an Australian rural setting: the role of the clinical facilitator', *Nurse Education in Practice*, vol. 12, no. 6, pp. 333-339.

Sarangi, S. 2010, 'Practising discourse analysis in healthcare settings', in I. Bourgeault, R. Dingwall & R. de Vries (eds), *The SAGE handbook of qualitative methods in health research*, SAGE, Los Angeles, pp. 397-416.

Saxena, M. 2010, 'Reconceptualising teachers' directive and supportive scaffolding in bilingual classrooms within the neo-Vygotskyan approach', *Journal of Applied Linguistics & Professional Practice*, vol. 7, no. 2, pp. 169-190.

Schieffelin, B.B. & Ochs, E. (eds) 1986, *Language socialization across cultures*, Cambridge University Press, Cambridge.

Schiffrin, D. 1994, *Approaches to discourse*, Blackwell, Oxford.

Schön, D. 1983, *The reflective practitioner*, Basic Books, New York.

Scribner, S. & Cole, M. 1973, 'Cognitive consequences of formal and informal education', *Science,* vol. 182, no. 4112, pp. 553-559.

Scribner, S. & Cole, M. 1981, *The psychology of literacy*, Harvard University Press, Cambridge, MA.

Sedgwick, C., Garner, M. & Vicente-Macia, I. 2016, 'Investigating the language needs of international nurses: insiders' perspectives', *IELTS Research Reports*, vol. 2, viewed 3 May 2017, <http://www.ielts.org/researchers>.

Shrubshall, P. & Roberts, C. 2005, *Case study six: being a nurse and following new rules: institutional and professional discourses in a preparatory course for supervised practice for overseas nurses*, National Research and Development Centre for Adult Literacy and Numeracy, London.

Sinclair, J. & Brazil, D. 1982, *Teacher talk*, Oxford University Press, Oxford.

Sinclair, J. & Coulthard, R. 1975, *Towards an analysis of discourse: the English used by teachers and pupils*, Oxford University Press, London.

Skøien, A.K., Vågstøl, U. & Raaheim, A. 2009, 'Learning physiotherapy in clinical practice: student interaction in a professional context', *Physiotherapy Theory & Practice*, vol. 25, no. 4, pp. 268-278.

Slade, D., Manidis, M., McGregor, J., Scheeres, H., Stein-Parbury, J., Dunston, R., Stanton, N., Chandler, E., Matthiessen, C. & Herke, M. 2011, *Communicating in hospital emergency departments*, University of Technology, Sydney, Sydney.

Solomon, N., Boud, D. & Rooney, D. 2006, 'The in-between: exposing everyday learning at work', *International Journal of Lifelong Education*, vol. 25, no. 1, pp. 3-13.

Spafford, M.M., Schryer, C.F. & Creutz, S. 2009, 'Balancing patient care and student education: learning to deliver bad news in an optometry teaching clinic', *Advances in Health Sciences Education* vol. 14, no. 2, pp. 233-250.

Spiers, J.A. 2002, 'The interpersonal contexts of negotiating care in home care nurse-patient interactions', *Qualitative Health Research*, vol. 12, no. 8, pp. 1033-1057.

Spouse, J. 1996, 'The effective mentor: a model for student-centred learning in clinical practice', *Nursing Times Research,* vol. 1, no. 2, pp. 120-133.

Spouse, J. 1997, 'Issues in observing nursing students in clinical practice', *Nursing Times Research*, vol. 2, no. 3, pp. 187-196.

Spouse, J. 1998a, 'Learning to nurse through legitimate peripheral participation', *Nurse Education Today*, vol. 18, no. 5, pp. 345-351.

Spouse, J. 1998b, 'Scaffolding student learning in clinical practice', *Nurse Education Today*, vol. 18, no. 4, pp. 259-266.

Spouse, J. 2001, 'Bridging theory and practice in the supervisory relationship: a sociocultural perspective', *Journal of Advanced Nursing*, vol. 33, no. 4, pp. 512-522.

Srivastava, P. & Hopwood, N. 2009, 'A practical iterative framework for qualitative data analysis', *International Journal of Qualitative Methods*, vol. 8, no. 1, pp. 76-84.

Stoller, P. & Olkes, C. 2013, *In sorcery's shadow: a memoir of apprenticeship among the Songhay of Niger*, University of Chicago Press., Chicago.

Street, B. 2012, 'New literacy studies', in M. Grenfell, D. Bloome, C. Hardy, K. Pahl, J. Rowsell & B. Street (eds.), *Language, ethnography and education: bridging New Literacy Studies and Bourdieu*, Routledge, New York, pp. 27-49.

Stubbe, M. 2010, '"Was that *my* misunderstanding?" Managing miscommunication and problematic talk at work', PhD thesis, Victoria University of Wellington, New Zealand.

Symes, L., Tart, K., Travis, L. & Toombs, M.S. 2002, 'Developing and retaining expert learners: the student success program', *Nurse Educator*, vol. 27, no. 5, pp. 227-231.

Tannen, D. & Wallat, C. 1987, 'Interactive frames and knowledge schemas in interaction: examples from a medical examination/interview, ' *Social Psychology Quarterly*, vol. 50, no. 2, pp. 205-216.

Tanner, C.A. 2006, 'Thinking like a nurse: a research-based model of clinical judgment in nursing', *Journal of Nursing Education*, vol. 45, no. 6, pp. 204-211.

Toohey, K. & Norton, B. 2003, 'Learner autonomy as agency in sociocultural settings', in D. Palfreyman & R. Smith, C. (eds), *Learner autonomy across cultures: language education perspectives*, Palgrave Macmillan, Basingstoke, pp. 58-72.

Trede, F. & Smith, M. 2012, 'Teaching reflective practice in practice settings: students' perceptions of their clinical educators', *Teaching in Higher Education*, vol. 17, no. 5, pp. 615-627.

Tusting, K. 2005, 'Language and power in communities of practice', in D. Barton & K. Tusting (eds), *Beyond communities of practice: language, power, and social context*, Cambridge University Press, New York.

Valdez, L.P.M., de Guzman, A.B. & Escolar-Chua, R.L. 2013, 'Every move counts in learning: Filipino clinical instructors' scaffolding behaviors in teaching medication administration', *Nurse Education Today*, vol. 33, no. 10, pp. 1214-1218.

van Lier, L. 1996, *Interaction in the language curriculum: awareness, autonomy and authenticity*, Pearson Education, Harlow.

van Lier, L. 2001, 'Constraints and resources in classroom talk: issues of equality and symmetry', in C. Candlin & N. Mercer (eds), *English language teaching in its social context*, Routledge, London, pp. 90-107.

Veen, M. & de la Croix, A. 2016, 'Collaborative reflection under the microscope: using conversation analysis to study the transition from case presentation to discussion in GP residents' experience sharing sessions', *Teaching and Learning in Medicine*, vol. 28, no. 1, pp. 3-14.

Vezeau, T.M. 2016, 'In defense of clinical conferences in clinical nursing education', *Nurse Education in Practice*, vol. 16, no. 1, pp. 269–273.

Vygotsky, L.S. 1962, *Thought and Language*, MIT Press, Cambridge, MA.

Vygotsky, L.S. 1978, *Mind in Society*, Harvard University Press, Cambridge, MA.

Wang, C.W., Singh, C., Bird, B. & Ives, G. 2008, 'The learning experiences of Taiwanese nursing students studying in Australia', *Journal of Transcultural Nursing*, vol. 19, no. 2, pp. 140-150.

Watson-Gegeo, K.A. 2004, 'Mind, language, and epistemology: towards a language socialization paradigm for SLA', *The Modern Language Journal*, vol. 88, no. 3, pp. 331-350.

Wells, G. 1999, *Dialogic inquiry: Towards a sociocultural practice and theory of education*, Cambridge University Press, Cambridge.

Wenger, E. 1998, *Communities of practice: learning, meaning and identity*, Cambridge University Press, Cambridge.

Wette, R. 2011, 'English proficiency tests and communication skills training for overseas-qualified health professionals in Australia and New Zealand', *Language Assessment Quarterly*, vol. 8, no. 2, pp. 200-210.

White, C. 2010, 'A socio-cultural approach to learning in the practice setting', *Nurse Education Today*, vol. 30, no. 8, pp. 794-797.

Wickers, M.P. 2010, 'Establishing the climate for a successful debriefing', *Clinical Simulation in Nursing*, vol. 6, no. 3, pp. e83-e86.

Wink, D.M. 1995, 'The effective clinical conference', *Nursing Outlook*, vol. 43, no. 1, pp. 29–32.

Wong, F.K.Y. & Lee, W.M. 2000, 'A phenomenological study of early nursing experiences in Hong Kong', *Journal of Advanced Nursing*, vol. 31, no. 6, pp. 1509-1517.

Wood, D., Bruner, J.S & Ross, G. 1976, 'The role of tutoring in problem solving', *Journal of Child Psychology and Psychiatry*, vol. 17, no. 2, pp. 89–100.

Woodward-Kron, R., Hamilton, J. & Rischin, I. 2007, 'Managing cultural differences, diversity and the dodgy: overseas-born students' perspectives of clinical communication in Australia', *Focus on Health Professional Education: A Multi-disciplinary Journal*, vol. 9, no. 3, pp. 30-43.

Woodward-Kron, R., van Die, D., Webb, G., Pill, J., Elder, C., McNamara, T., Manias, E. & McColl, G. 2012, 'Perspectives from physiotherapy supervisors on student-patient communication', *International Journal of Medical Education*, vol. 3, pp. 166-174.

Xu, Y. & Davidhizar, R. 2005, 'Intercultural communication in nursing education: when Asian students and American faculty converge', *Journal of Nursing Education*, vol. 44, no. 5, pp. 209-215.

Yang, A. 2009, 'Coming home to nursing education for a Hmong student, Hmong nurse, and Hmong educator', in S.D. Bosher & M.D. Pharris (eds), *Transforming nursing education: the culturally inclusive environment*, Springer Publishing Company, New York, pp. 103-128.

Zarrinabadi, N. 2014, 'Communicating in a second language: investigating the effect of teacher on learners' willingness to communicate', *System*, vol. 42, pp. 288-295.