Appreciating complexity, context and continuum in undergraduate nurse clinical education: English and Australian perspectives

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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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'Dare quam accipere'[1]

To give than to receive

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[1] 'Dare quam accipere' - the motto of Guy's Hospital. Location for my own nursing education 1984-1987. From Survey of London: Volume 22, Bankside (The Parishes of St. Saviour and Christchurch Southwark), Eds. Roberts, H and Godfrey, W H (London, 1950), pp. 36-42. British History Online http://www.british-history.ac.uk/survey-london/vol22/pp36-42 [accessed 7 October 2017].

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Publications

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Glossary of Terms

Term	Abbrv.	Definition/Explanation	Reference or Source (as applicable)
Assistant in Nursing	AIN	Assistants in nursing work under the supervision of the Registered Nurse and within a plan of care and the limits of the Assistant in Nursing position description	NSW Health (2010) Position Description
Augmented Reality		'The combination of reality and overlay of digital information designed to enhance the learning process'.	Lopreiato, et al. (2016, p. 4) *Healthcare Simulation Dictionary.*
Australian Commonwealth Supported Student		A Commonwealth supported place (CSP) is a subsidised higher education enrolment. Part of the fees are paid directly to the university by the Australian Government. This is not a loan and students do not have to pay the subsidy back. Only domestic students can access CSPs.	Australian Government Study Assist website: http://studyassist.gov.au/sites/StudyAssist/
Buddy RN, Buddy nurse		'The RN Buddy is a registered nurse, often previously unknown to students, assigned by nurse managers or shift coordinators to work with a student for a shift at a time'.	Walker, Cooke & McAllister (2008, p. 761)
Bursary		An annual payment from the National Health Service (NHS) to help with study and living costs.	GOV.UK NHS Bursaries
Care Workers		Also referred to as nurse aides, nurse assistants or personal care workers. Care workers provide a large percentage of the care in residential aged care facilities. This workforce is not governed by national professional standards	https://www.australianageingagenda.com.au/2016/06/08/new-code-of-conduct-covering-aged-care-workers-what-you-need-to-know/
Clinical assessment document		Generic term adopted for the required clinical assessment document, though at either study site more specific terms may apply.	
ClinConnect		ClinConnect is a web-based system used to book, manage and record all clinical placements in NSW Health facilities.	Health Education and Training Institute (HETI): http://www.heti.nsw.gov.au/clinconnect/
Clinical Facilitator or University appointed Facilitator		A clinical facilitator (or University Appointed Facilitators) are Registered Nurses (RN) employed by the universities to supervise, support and assess nursing students in practice on clinical placements.	Andrews & Ford (2013)
Clinical Nurse Consultant	CNC	The CNC role was established in NSW in 1992. This advanced nursing role has functions in 'clinical service and	Wilkes, Luck & O'Baugh (2015, p.1)

		consultancy; clinical leadership; research; education; and clinical service planning'.	
Direct and indirect		Terms used in Chapter Two to distinguish the students experience being reported in the papers included in the literature review. Direct - where students experience 2 or more models of clinical experience and so can make a direct comparison of experience. Indirect - were studies comparison are made to cohorts of student where each cohort experience a different clinical education model.	
Facility Appointed Base Facilitator	FAB	Facility Appointed Base-Facilitators (FAB) supervise students in a model of student supervision where the health facility provides a member of facility staff as the student supervisor for the duration of the students' placement.	
Fields of study/practice (UK)		In the UK, nursing student study a specific field of practice as part of their nursing degree. There are four fields of nursing: • adult nursing • children's nursing • learning disabilities nursing • mental health nursing'.	NMC (2010)
Healthcare Assistants	HCA	Healthcare Assistants (HCAs) may work under the direction of various healthcare professionals. Across a range of acute care or community settings. Role and duties vary depending on the nature of the healthcare setting.	The Open University: https://www.open.edu.au/
Health Education England	HEE	HEE is a non-Departmental Public Body established under the provisions of the Care Act (2014). Its role is to make sure there are sufficient skilled healthcare professionals to meet demand for to provide quality healthcare.	https://hee.nhs.uk/
Higher Education Institution		The terms education provider, higher education provider and tertiary education are all used to refer to institutions offering undergraduate or pre-registration nursing programs	
Hub and Spoke		'Hub and Spoke' is a clinical learning model where the Hub is the students' main placement base and the Spokes are secondary places, often related to the Hub	Millar, L. (2014)

		where students gain wider or additional experiences	
Learning Environment Manager	LEM	As defined by Congdon et al. 2013, the Learning Environment Manager role centers on 'dedicated local responsibility for the management of practice learning within each ward and department involved in the education of undergraduate student nurses'.	Congdon, Baker & Cheesman (2013, p.137)
Link Lecturer (UK)		The link lecturer role can be part of the role of university based lecturers. The role provides direct and indirect support to the clinical area, healthcare staff and support for student nurses in clinical practice.	MacIntosh (2015) and NMC (2008)
Mentor and mentorship		A mode of student supervision within the clinical learning environment. The student engages in clinical practice under the supervision of a clinical nurses who takes on the role of mentor. The mentors supports student learning and is required to assess and make judgment about student's performance and attainment of clinical skills.	Jokelainen et al. (2013b)
Models of clinical education		A variety of conceptualised approaches exist for provision of clinical learning experiences, with varying practice education and/or supervision models described. Examples include the traditional or block rotational, the preceptorship model and collaborative education unit models.	Budgen & Gamroth (2008); (HWA 2012)
Module		General term used in this thesis to describe the units of study that comprises the preparatory nursing program as a whole.	
NHS Trust		Most healthcare services in the UK are provided through NHS foundation trusts and NHS trusts, organisational units within the NHS. Most hospitals are managed by NHS Foundation Trusts, which are independent legal entities and have unique governance arrangements.	
Nurse Unit Manager	NUM	The NUM is 'the registered nurse in charge of a ward or unit or group of wards or units in a public hospital or health service or public health organisation'.	NSW Public Health System Nurse' & Midwives' (State) Award: http://www.nswnma.asn.au/industrial-issues/awards-and-conditions/public-health-system/

Nursing and Midwifery Board of Australia	MBA	Governing body which sets policy and professional standards for nursing and midwifery, registers practitioners and handles complaints. The board is also responsible for the accreditation of courses of study.	http://www.nursingmidwiferyboard.gov.au/
Personal tutor		A small group of students are assigned a personal tutor for the duration of their study which promotes the development of a supportive relationship between an identified staff member and student. Advanced versions of the approach may bring student groups come together for class/small group sessions.	
Placement		An episode of student in situ clinical or practice experience.	
Placement Unit		Generic term for the organisational and administrative unit(s) responsible for clinical placement logistics and administration.	
Practice Education Facilitator (PEF) (UK)		Based in the healthcare setting, PEF's contribute to high-quality learning experience for students. This is facilitated via support and development of mentors, trouble shooting and providing liaison between the healthcare setting and university	Carlisle, Calman & Ibbotson 2009, Scott et al. (2017)
Pre-registration		Pre-registration is the term commonly associated with preparatory undergraduate nursing programs in the UK	
Professional Staff within HEI		Higher education institute staff in a range of roles that support program delivery including administrative, technical and managerial roles	
Simulation		'A technique that creates a situation or environment to allow persons to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions.'	Lopreiato et al. (2016, p.33)
Simulation Based Learning Experiences		'An array of structured activities that represent actual or potential situations in education and practice. These activities allow participants to develop or enhance their knowledge, skills, and attitudes, or to analyse and respond to realistic situations in a simulated environment'.	Lopreiato et al. (2016, p.32)

Student supervision		The term used in this thesis to denote the process of student supervision when a generic term is required.	
Supervisor		The generic term used in this thesis to denote students' supervisor, the person with direct responsibility of supporting, teaching and assessing undergraduate student nurses. This is distinct from the term clinical supervision as used in relation to registered practitioners' professional development.	
Virtual Reality		'The use of computer technology to create an interactive three dimensional world in which the objects have a sense of spatial presence; virtual environment and virtual world are synonyms for virtual reality'.	Lopreiato et al. (2016, p.40)

List of Acronyms

AIN	Assistant in Nursing
ANMAC	Australian Nursing and Midwifery Accreditation Council (Australia)
CNC	Clinical Nurse Consultant
EU	European Union
FAB	Facility Appointed Base Facilitator
HCA	Health Care Assistant
HEE	Health Education England
HETI	Health Education Training Institute
HWA	Health Workforce Australia
MDT	Multi-disciplinary Team
NBA	Nursing and Midwifery Board of Australia
NMC	Nursing and Midwifery Council (UK)
NHS	National Health Service
NUM	Nurse Unit Manager
PEF	Practice Education Facilitator
WHO	World Health Organisation

ABSTRACT

Clinical learning experiences have long been considered a vital component of preparatory nurse education programs. Internationally, however, reports indicate providing sufficient quality experiences is increasingly challenging, as the demand for new nurses intensifies to address nurse shortages and replenish an aging nursing workforce. In addition, there is a need to meet the demands of societal and population changes which, in turn, are driving change and growth in healthcare policy and provision.

This doctoral study aimed to generate an enhanced understanding of the factors that are conducive to promoting the quality and meaningfulness of the students' clinical learning experience, and identify the individual and organisational factors that support this. Further, the study sought contemporary affirmation of the unique role of clinical learning in becoming a nurse and to envision how the design of innovative, sustainable clinical learning experiences can be promoted into the future.

This study used a qualitative methodology, guided by an appreciative inquiry framework to identify enablers and barriers within clinical education to determine future direction. A two site, cross national study using an embedded case study design, explored the approaches to clinical education in two nursing programs – one in England, United Kingdom and one in New South Wales, Australia. Data were collected using semi-structured interviews (academic and professional staff n=43) and questionnaires (staff n=5, final year students n=78). Thematic analysis and cross-case synthesis were undertaken.

Three major themes emerged from the data: the student experience, the organisational dimension of clinical placements and connecting with the past to create the future. The student experience centred on the people students' encounter, their facilitated engagement as part of the healthcare team, and sufficient opportunities to develop and challenge their practice in order to transition to becoming a nurse. The second theme revealed the complex 'hinterland' at the interface of higher education and healthcare that facilitates placement and student supervision and the merits of the various program features, including placement duration. The findings in the third theme reflect the evolution of nurse education and the parallel shift in nurse and nursing identity over time. Visualising the context and the complex myriad of influences and interconnections spanning individual, organisational and professional domains was aided by a conceptual model, developed using ecological systems theory.

The findings of this thesis provide greater insight into clinical education, the need to continue to promote a shared healthcare and education collaboration in nurturing next generation nurses

and the importance of facilitating engagement in authentic practice at the core of meaningful clinical learning experiences. The findings of this thesis suggest that meaningful experiences are more than the sum of their parts and to identify innovate future designs, modelling the system as a whole is warranted. There is also scope to be flexible and inventive, as 'one size does not fit all' as the needs of students, clinical settings and the profession will continue to evolve over time.

PREFACE

'The word is about, there's something evolving,
whatever may come, the world keeps revolving
They say the next big thing is here,
that the revolution's near,
but to me it seems quite clear
that it's all just a little bit of history repeating'

History Repeating[2] Alex Gifford (1997)

This preface provides insight into the personal motivation that set me on a particular line of inquiry, culminating in the thesis presented here.

The preparatory education of registered nurses is constantly evolving. Recent global advances have resulted in nurse education, in many countries, moving into the higher education sector with a degree being the primary preparation for nurses. Despite this significant shift, the extent to which nurse education has changed is widely debated; as evidenced by this observation made at the United Kingdom's Willis Commission inquiry (2012) into pre-registration nursing education:

> ...the process of preparing nurses has not changed very much since I trained. The location has changed, the intent has changed, but the reality is that it has not changed at all except around the edges... *Professor Dame Jill Macleod Clark (2012)*[3]

This comment resonated with my own experience of hospital-based training and current contemporary engagement with nurse education programs. In particular, the traditional block style approach to clinical education, at a surface level at least, appears largely unchanged from previous apprenticeship programs. Having long involvement with the provision of clinical experiences or *placements*, I was cognisant that this aspect of nurse education is an increasingly complex undertaking with contemporary challenges, alongside pressing calls for change. Yet, when asking Australian nursing students about their clinical experiences, replies such as, *"it was*

[2]The song History Repeating, written by Alex Gifford, originally performed in 1997 by the Propellerheads, featuring Dame Shirley Bassey
[3]Transcript of evidence given to the Willis Commission Inquiry 2012

awesome![4]" indicated that clinical placements could not only *work*, but could *work well.* For students, despite the challenges, the vast spectrum of placement settings and relative unpredictability of the learning opportunities, clinical experiences offer a unique essence, with students having positive, even transformational experiences advancing them on their journey to becoming a nurse.

Consequently, the spark initiating this study was my desire to enhance understanding of the key elements that contribute to and promote these *awesome* experiences, to value and retain the *bes*t of what already exists, as a platform for change:

> How can we enhance and utilise the structures, resources and processes already present to improve the equity and effectiveness of education?
>
> (Synder 2013, p.10)

Key drivers for reform in the preparation of nurses are the highly dynamic systems of healthcare and education, which are in a state of constant flux, evolving and adapting to meet changing societal needs and demands. Hence, it is warranted to move forward from an established base to develop new ways to question and examine the complexity in educational redesign, rather than simplifying and adopting changes of a 'fashion and fad' or cyclic 'we've seen it before' nature (Gifford 1997).

This doctoral study draws on my experience of the registered nurse education systems in England, UK and in New South Wales, Australia, to better appreciate the key elements, regardless of the education system that contribute to students' meaningful placement experiences. This study has generated a systems model to better understand the 'interactive network of forces' that Dunn and Burnett (1995, p.1166) suggest comprise the clinical learning environment and influence 'student learning outcomes in the clinical setting'. Building from, and valuing, *what works well* and asking *what could be* offers a novel approach to capture the best of the past, the present and to both inform the future education of nurses and reinforce the unique contribution of authentic, real world experiences in becoming a nurse.

[4] Awesome – defined as 'extremely impressive or daunting; inspiring awe' and informally as 'extremely good; excellent' (Oxford Dictionaries Online 2017).

CHAPTER ONE: BACKGROUND – SETTING THE SCENE

1.1: Introduction

Creating safe, competent, compassionate beginning professionals who are 'fit for practice…' (Ball 2006, p.4) is the key goal of nurse education. Episodes of supervised clinical learning (Mannix et al. 2006) designed to meet the requirements stipulated by registration or accrediting bodies are integral to nurses development (ANMAC 2012; NMC 2010). The importance of undergraduate clinical learning experiences has long been acknowledged as vital (Field 2004; McKenna & Wellard 2004; Midgley 2006). Whilst a challenging, component of preparatory programs (Ironside, McNelis & Ebright 2014), quality clinical experiences are a significant factor in students completing their nursing studies (Crombie et al. 2013). These experiences also underpin the acquisition of professional competency and identity (Courtney-Pratt et al. 2012; Sandvik, Eriksson & Hilli 2015)

The experiential learning associated with real world clinical practice plays a fundamental role in providing nursing students with opportunities to nurture the knowledge, skills, abilities and emotional attributes necessary for their successful assimilation and integration into the healthcare workforce (Jackson & Mannix 2001; Mallik & Aylott 2005; Willis 2012). In addition, clinical learning experiences promote the socialisation of nursing students to professional nuances and exposes them to the regulatory standards required for practice. Benner et al. (2010) propose that this socialisation process ought to provide transformational experiences that emphasise the development of professional identity throughout the student's journey to becoming a nurse.

Yet, despite these benefits, clinical experiences have traditionally been notoriously difficult to manage (Levett-Jones et al. 2006). As demand for access to clinical settings for placements intensifies (Jackson & Watson 2011; Smith, Corso & Cobb 2010), managing the student's clinical experience becomes more challenging. Preparatory nurse education faces emergent challenges arising from societal and population changes, an aging nursing workforce, staff shortages and shifting healthcare policy which are of local and international concern (Daly et al. 2008; Holland et al. 2010; Smith, Corso & Cobb 2010). Further, the concomitant drive to increase health care worker numbers, including nurses, as evident on the agendas of National governments (Health Workforce Australia (HWA) 2013; MacMillan 2013) and the World Health Organization (WHO) (2011) further impacts supply and demand.

Consequently, Jackson et al. (2013) refer to the clinical component of education programs as the 'Achilles' heel of healthcare profession curricula and warn against seeking inappropriate or reactive short term solutions that will not sufficiently or sustainably address the inherent issues and

challenges. A reactive approach to the increased demand for clinical placements would also risk overlooking current strengths or limiting innovation. As Buchan (2001) cautions, this would miss the goal to educate nurses who deliver better nursing care rather than simply producing more nurses. Indicative of the current discourse, Ironside, McNelis and Ebright et al. (2014) and Benner et al. (2010) call for a rethinking of clinical education, particularly to address future demand for quality clinical placements that will best prepare students for practice. In addition, there is a need for consideration of sustainable and future proof solutions that meet diversifying need (Carrigan 2012; Glasgow; Dunphy & Mainous 2010; Keighley 2013).

In this introductory chapter, an exploration of the context and background to the doctoral study is presented. A consideration of the approaches to clinical education, and some of the key concepts and terminology is explored. The challenges, both past and present, in the provision of clinical education are discussed incorporating an extract from a published overview of the literature (Forber et al. 2015). This leads into the conceptualisation of this study, which examines the provision of meaningful clinical experiences from the perspectives of higher education staff and final year students at two universities. The main research aim and objectives are presented, before a final brief synopsis of each chapter acts as a navigational guide to the thesis.

1.2: Clinical experiences in undergraduate nurse education

Implementing strategies for nurse education has evolved from hospital-based apprentice training to higher education degree level preparation in countries including Australia and the United Kingdom (UK) (ANMAC 2012; NMC 2010; Willis 2012). Governance for nurse education is provided by centralised bodies, such as, the UK's Nursing and Midwifery Council (NMC) and the Australian Nursing and Midwifery Accreditation Council (ANMAC). These organisations issue higher education providers with standards for undergraduate education, rather than the previously heavily prescribed national curricula, as frameworks to ensure students achieve competency and are fit for practice on graduation (ANMAC 2012; NMC 2010).

Detailed within the standards are the requirements for undergraduate nursing programs of study, including the clinical component. Despite the consensus that supervised real life clinical experiences are essential for undergraduate nursing programs (HWA 2012; Willis 2012), numerous approaches to achieving this ideal prevail, with national and international variation. At a program level, undergraduate nurse education programs can be considered either generalist leading to a single registered qualification, as in Australia (ANMAC 2012) or more specialist, as in UK programs, leading to registration in adult, child, mental health or learning disability nursing (NMC 2010).

Within undergraduate/pre-registration nurse education a variety of *models* of clinical education have evolved over time. Many models of clinical education are framed by their approach to supervision (Henderson, Happell & Martin 2007) rather than an overarching philosophy. However, the focus of the clinical learning experience is to expose the student nurse to the real world of practice and to engage in learning opportunities under the supervision of an experienced guide. Within the provision of clinical education experiences for undergraduate nursing students, these core variables are susceptible to the effects of a range of influences and challenges.

1.3: Influences in the provision of clinical education

The influences and challenges for clinical education include some of the legacies of the past that have shaped and influenced clinical education format and delivery. In addition, contemporary challenges relate to influences on supply and demand; the disconnect between healthcare and education; healthcare reforms, changes to the nurse's role; and the determination of fitness for practice.

The following section of this background chapter is an edited and adapted extract from the published manuscript[5] written as part of the work associated with this thesis (Appendix 1).

1.3.1: Legacies of the past

Regardless of the ideological shift from training to education (Bradshaw & Merriman 2008), and the model of clinical education, features emanating from the hospital apprenticeship models still prevail. This is evident in the common term 'clinical placement' which Roxburgh, Conlon and Banks (2012) suggest implies that learning can be contained within the boundaries of a physical location, specific team, patient population or time. As part of a rotational access model, students are allocated to various placements in different settings, with diverse patient populations and clinical supervisors with 'no defined connection between them' (Roxburgh, Conlon & Banks 2012, p.783). This rotational access model may be driven by availability and competition rather than the educational needs of the curriculum or learner (Holland et al. 2010). Further, the rotational model can result in disconnected experiences (Campbell 2008) with students unsure how particular settings meet their specified or personal learning objectives (Mannix et al. 2006).

[5] Forber, J, DiGiacomo, M, Davidson, P, Carter, B, & Jackson, D 2015, 'The context, influences and challenges for undergraduate nurse clinical education: Continuing the dialogue', Nurse Education Today, Vol. 35, No. 11, pp. 1114-1118.

Historically, rotational access models have centred on the acute care settings where high acuity, rapid patient turnover, specialisation, need to ensure patient safety and increasing numbers of learners may not guarantee that appropriate learning opportunities avail themselves. Lauder (2008) comments that acute care settings emphasise *illness* and *patients*, thus promoting the medical model rather than person centred, social models of health. Continued reliance on the acute care setting will not adequately prepare students for growth areas, namely primary healthcare or community-based employment. Another common practice is for students to provide total patient care to increasing numbers of patients as they progress through their program of study. Benner et al. (2010) caution that there is a misguided assumption that this makes students more 'work ready' on completion and suggest that alternate ways for students to progress, develop and increase independence are needed.

The move to tertiary education conferred supernumerary status on students, giving rise to the need for new models of student supervision. In their review, Budgen and Gamroth (2008) identified 10 clinical (or practice) education models, of these six focused on student education, and four models combined education with student employment. Many of the models often emphasise the mode of student supervision, rather than an overarching approach to teaching and learning. A spectrum of differing models and definitions of student supervision has evolved with a variety of terms used, sometimes interchangeably, including: 'supervising', 'mentoring', 'facilitating' and/or 'preceptoring'. For example, mentoring utilises clinically-based nurses, as the nurse mentor, and student supervision is part of the nurse's standard role (Jokelainen et al. 2011). Alternatively, in the clinical facilitator or faculty supervised models, registered nurses (RNs) are employed by the higher education institution (HEI) to supervise students, typically in a 1:8 ratio and over several wards or units (Courtney-Pratt et al. 2012; Budgen & Gamroth 2008).

The preparation and governance of student supervisors, regardless of the model, also differs. In the UK, the Nursing and Midwifery Council's (NMC 2008) Standards to Support Learning and Assessment in Practice detail a formalised, nationwide structure. In contrast, with no formalised national structure in Australia, the need for greater consistency in supervisor preparation and governance has been called for (Andrews & Ford 2013).

Further variables are the numerical parameters of undergraduate clinical education, these include: the total practice hours stipulated by governing bodies; the duration, number and type of placements or experiences; the range of shifts; and number and type of patients a student cares for. Illustrative of this is the disparity in student clinical practice hours within preparatory programs; the European Union (EU) requirement of 2300 hours (EU 2005/36), for example,

contrasts with Australia's minimum of 800 hours (ANMAC 2012). The duration of clinical exposure, along with its organisation and the complex issue of assessment of competence are factors to consider when student exchange and, more significantly, potential mobility of the global nursing workforce are considered (Dobrowolska et al. 2015). This may be particularly pertinent to countries reliant on a migrant workforce to sustain the nursing workforce.

These factors exemplify the complexities and anomalies that intrinsically exist in undergraduate nurse clinical education, which are amplified in the context of contemporary issues such as population, healthcare and nursing workforce changes.

1.3.2: Challenges of the present

Supply and Demand - The nursing workforce is aging, with the median nurse age, for example, reported by the Australian Institute of Health and Welfare (AIHW) (2012) as 44.5 years and the Canadian Institute for Health Information (CIHI) stating 45.4 years (CIHI 2011). As this sector of the nurse workforce moves towards retirement over the next 10-15 years, a looming void contributes to projected nursing workforce deficits in countries including Australia, the United Kingdom and US (National Health Workforce Taskforce (NHWT) 2009; Sherman, Chiang-Hanisko & Koszalinski 2013). In addition, high rates of attrition, especially amongst early career nurses further compound predicted workforce shortfalls (Doiron, Hall & Jones 2008). These deficits occur at a time of growing demand for healthcare services, driven by societal changes, such as the growing aged population, evident in many countries (European Commission 2012) and greater nursing involvement in aged care, primary and sub-acute care settings (ANMAC 2012; Smith, Spadoni & Proper 2013). Paradoxically, as the world faces increasing numbers of individuals with progressive chronic illnesses and disability, the contraction in the availability of clinical sites, creates a challenge in achieving sufficient direction for appropriate workforce development.

A traditional strategy to boost supply is to increase undergraduate numbers in nursing programs (Sherman, Chiang-Hanisko & Koszalinski 2013). Buerhaus et al. (2013) see younger people entering nursing in large numbers, as key in delivering the growth in the nursing workforce over the period 2020-2030. However, Buchan, O'May and Dussault (2013) caution that having more nurses is not a solution in itself and a coordinated multi-faceted approach is required. The ramifications of efforts to boost supply, are demonstrated in Health Workforce Australia (HWA 2013) data which shows that 11,046 students commenced Australian undergraduate nursing programs in 2005, increasing to 16,328 in 2011. This 48% increase in students, creates a substantial increased demand for quality clinical placements and impacts on healthcare services

and staff capacity to support students. Jackson and Watson (2011) and Smith, Corso and Cobb (2010) note how increased student numbers contributes to another 'supply and demand' situation, increasing competition amongst providers of nurse education. Large first year nursing student cohorts (n=806) (Salamonson et al. 2012) places considerable local pressure on healthcare organisations to provide clinical learning experiences. The increasing diversity in the age, English language proficiency and finances in nursing student cohorts can negatively impact on clinical experiences and require attention to clinical placement design and delivery (Koch et al. 2014). Understandably, in this drive to increase 'quantity' it is debated whether sufficient attention has, will or can be given to the 'quality' of clinical education (Levett-Jones 2007, Roxburgh, Conlon & Banks 2012).

Disconnection - The shift of nursing education into the tertiary sector has resulted in what Allan (2010) terms, an 'uncoupling' of health and education with a perceived lack of leadership for nurse education. O'Driscoll, Allan and Smith's (2010) case study of four UK health service trusts found that whilst nurse ward managers had strategic responsibility for education and the clinical learning environment, ward managers lacked a direct role in student learning. Responsibility for student supervision and education now falls largely to the registered nurse (RN) who, focused on patient care delivery, can feel unprepared and unsupported in their student supervisory role (O'Driscoll, Allan & Smith 2010). Where the clinically-based RN acts as the student supervisor (mentoring), issues with the lack of preparation, confidence, recognition, time and organisational support are potential barriers to effective supervision (Courtney-Pratt et al. 2012; Myall, Levett-Jones & Lathlean 2008). Greater recognition of the role ward-based RN supervisors play in students' development has been recommended, requiring the nurse managers to better support the RN's preparation and development for the role, underpinned with effective communication channels (Myall, Levett-Jones & Lathlean 2008).

In contrast, in models of student supervision where the education institution provides the student supervisor, for example clinical facilitator models, other issues arise. Here both the supervisor (clinical facilitator or 'faculty') and student are 'guests' in a facility, necessitating that the supervisor develop alliances to identify learning opportunities and engage facility staff in student support (Dickson, Walker & Bourgeois 2006). In clinical facilitation type approaches, the bedside RN continues to play a vital role guiding students when the facilitator is unavailable. However, heavy workloads, time constraints and sheer numbers of students can affect the 'buddy' RN's ability to spend time with students (Courtney-Pratt et al. 2012).

Healthcare reform - Healthcare restructuring and reform has changed the nurse's role. The increased prevalence of non-registered support roles, have effectively reduced the capacity of healthcare providers to host student clinical placements (Allan & Smith 2009; Smith, Corso & Cobb 2010). In the UK, Allen and Smith (2009) found the increase in non-registered support roles, for example, Assistant in Nursing (AIN), has resulted in the RN becoming the prescriber of care rather than the provider of care. Subsequently, one consequence is that students may not perceive 'essential nursing care' as the role of the RN. Hasson, McKenna and Keeney (2013) semi-structured interviews with non-registered healthcare workers (n=59), found student nurses worked alongside them to deliver patient care, due to limited RN availability. Non-registered healthcare workers revealed they were unofficially or informally involved in student education, teaching students basic clinical and non-clinical tasks. Similarly, Annear, Lea and Robinson (2014) explored the potential for non-registered personal care workers to act as mentors to student nurses in the growing aged care sector. However, overcoming student's initial negative attitudes towards participating in hygiene and personal care under the supervision of care workers was a major challenge. Demonstrating the links between fundamental care activities, such as hygiene, to wider nursing competencies needed to be addressed to better conceptualise these facilities for placements (Annear, Lea & Robinson 2014). As yet not fully explored within the literature, non-RN roles and less traditional placement areas require consideration in workforce projection and planning due to their impact on diversification, skill mix, subsequent capacity to supervise and assess students and quality of student learning.

Determining 'fitness for practice' - Within the nursing profession, there is an all too common phrase, that new graduate nurses need to be prepared to 'hit the ground running' (Cross 2009: p. 57). Comments like this are indicative of a lingering perception that moving nurse education to degree-based preparation, has resulted in new graduates who are neither fit for practice nor purpose. Bradshaw and Merriman (2008) lament the limited clinical skills of new graduates and the loss of fixed syllabuses with regimented skills testing to prescribed standards. However, both the current high expectations and the focus on practical skills as a marker for competence upon registration are influenced by wider issues such as workforce shortages, skill mix changes and escalating clinical demands.

The desire for new nurses to fill a void may be indicative of the reality and demands of the contemporary workplace (Chernomas et al. 2010) rather than new nurses' lack of preparedness or short-comings of nurse education (Wolff, Pesut & Regan 2010). Holland et al.'s (2010) evaluation of the Fitness for Practice curriculum (UKCC 1999) in Scotland, found new graduates

were ‘fit for practice’ on registration, though lacking in confidence; an important factor but distinct to lacking competence. In their research on perceptions of ‘practice readiness’ (p. 191), Wolff, Pesut and Regan (2010) argue that the debate on the merit of the technically (apprentice) prepared nurse versus the professionally (higher education) prepared nurse, are ‘divisive and out-dated’ (p. 191). They propose the debate move towards achieving appropriate, supportive new graduate transition into various healthcare settings, where a myriad of influences, including staff shortages and emerging technologies impact the new graduates’ integration into the workforce (Wolff, Pesut & Regan 2010).

Nurse education and the competency debate are further fuelled by public opinion and media reaction, where sentimentality for the past, lack of insight into contemporary healthcare and romanticised nursing images are evident. Headlines in the UK media suggest that degree educated nurses are ‘too posh to wash’ or ‘too clever to care’ (Fawcett 2013, p 26) are myths dispelled by the Willis Commission (2012). When the Australian healthcare system was under scrutiny, Jackson and Daly (2008) presented a thought provoking snapshot of letters from Australian metropolitan newspapers, many critical of the university educated nurses, harping back to the *good* old days and unappreciative of a well-educated nurse workforce. The response to these contemporary challenges varies from the establishment of government agencies, for example Health Workforce Australia (HWA) to independent commissions, reporting the ‘health’ of pre-registration nursing education (Willis 2012). In addition, however, nurses are driving reforms to enhance the robustness of future solutions, as the following cases illuminate.

1.4: Emergent approaches to clinical education

In light of the challenges and acknowledging the potential for innovation, options for clinical education are emerging which address capacity and offer flexible approaches to clinical placement provision. The following are illustrative of the possibilities being explored and evaluated to inform future direction.

Nielsen et al. (2013) describe the Oregon Consortium for Nursing Education model (OCNE), a multi-stakeholder collaboration to re-design and diversify nurse education to meet changing healthcare needs (Gaines & Spencer 2013). A variety of clinical learning activities matched to the level of the student are incorporated into the model including case studies, key concepts, skill development, focused direct client care and integrative total care experiences. The model sequences activities and experiences in an increasingly complex scaffolding of skills, concepts or holistic case studies in preparation for episodes of integrated total patient care later in the

program (Nielsen et al. 2013). Another emergent model provides flexible, student focused, interconnected experiences with students based in a main location - the hub - with spokes, minor or alternate locations offering learning opportunities not available in the hub. Originating in Scotland, the Hub and Spoke Model, addresses the observation by Benner et al. (2010) that few clinical curricula allow students to follow patients or families over time and across healthcare settings (Roxburgh, Conlon & Banks 2012). Evaluation shows this model has promise as an alternative more fluid approach to the compartmentalised, rotational placement style learning (Roxburgh, Conlon & Banks 2012).

Models that promote collaboration between practice and education partners to support effective clinical experiences are the Dedicated Education Unit (DEU), Clinical Education Unit (CEU) or Collaborative Learning Unit (CLU) models. Defined by Moscato et al. (2007, p.32), a DEU is a health care setting where all staff engage in student learning with development 'into an optimal teaching/learning environment through the collaborative efforts of management, clinical faculty, and staff nurses'. Callaghan et al. (2009) found students benefited from observing the practice of many nurses, experiencing team-based care, communicating within the multidisciplinary team and building their own view of good practice. Other studies have found DEUs promote early identification of failing students (Moscato, Nishioka & Coe 2013), high standards of individualised patient care (Rhodes et al. 2012) and enhanced student acceptance into the healthcare team (Ranse & Grealish 2007).

Studies by Austria, Baraki and Doig (2013) and Ruth-Sahd (2011) have looked at student dyads as a means of creating a learning community. Students work in pairs with their assigned patient(s) and demonstrate enhanced student confidence, group processing, team work and decision making (Austria, Baraki & Doig 2013; Ruth-Sahd 2011). Student dyads may also have a role in increasing capacity as fewer RNs are required to work with students each day, making effective use of limited resources (Austria, Baraki & Doig 2013).

Finally, increasingly studies are examining the efficacy in replacing clinical experience hours with simulated learning experiences. The NMC (2010) supports up to 300 hours (13% of total hours) of clinical time in UK programs can be replaced by simulation. In the US, the replacement of 50% of 'traditional' clinical hours with simulation is under evaluation by the National Council of State Boards of Nursing's (NCSBN) Simulation Study (Hayden et al. 2014). Hayden et al. (2014) has reported early indications that the educational outcomes using simulation substitution are equitable to the outcomes in controls with traditional clinical hours, and graduates were prepared for clinical practice. However, Arthur, Levett-Jones and Kable (2013) caution that

quality simulation experiences must be effectively articulated with the curriculum, to reflect the required learning objectives and the development of high quality simulation resources including staff expertise with this medium must be supported. As Berragan (2011) states simulation provides a safe environment for the development of clinical skills but must also interface with actual clinical practice to be at its most effective.

1.4 1: Summary of the gaps

The continued evolution of healthcare delivery, societal changes, diversification of the student body, financial and other resource implications will continue to challenge the design and development of clinical learning experiences. Innovative, future facing, novel, and increasingly flexible approaches that optimise the use of resources and widen learning opportunities are increasingly necessary to ensure student immersion in meaningful learning experiences and to support their transition from their program of study ready for contemporary practice.

1.5 Conceptualising the doctoral study

At a time when providing clinical *placements* is threatened by long-standing and emergent challenges, invigorated thinking into *what works well* within current clinical education is necessary. In their study on the student experiences of patient care, Ironside, Diekelmann and Hirschmann (2005) suggest: 'students are perhaps our brightest hope for envisioning what to preserve and what to overcome as we reform and create compelling, student-centred practice nursing education' (p. 52). In addition, to truly innovate as Newton et al. (2009) assert clinical education must be cognisant of the needs of multiple stakeholders. As nurse education now sits within the education sector, it is also necessary to better understand the complex system of tertiary education and how its interface with the equally complex healthcare system, supports meaningful placement implementation. The nature of the learning takes place in the complex multi-system milieu and can be influenced by an array of intrinsic and extrinsic factors.

1.5.1: The student experience and satisfaction with clinical learning experiences

Studies have identified factors that contribute to students' positive experiences and satisfaction with the clinical component of their program of study. Feeling accepted and developing a sense of belonging are considered fundamentally important for satisfactory experiences of clinical education (Levett-Jones & Lathlean 2008). The formation of positive relationships that facilitate effective communication and collaboration between the student and their supervisor are also vital factors for student satisfaction (Brown et al., 2011, Courtney-Pratt et al., 2012, Levett-Jones

et al. 2009). The establishment of a positive relationship satisfies a student's need to feel supported by their mentor (Crombie et al 2013) and within a 'good' clinical environment, the registered nurse is encouraged to engage with students as part of the team (Thomson, Docherty & Duffy 2017). Where there is effective communication and collaboration between the student and their supervisor, Courtney-Pratt et al. (2012) identified this contributed to increased student confidence and a readiness to seek assistance when required.

The Clinical Learning Environment Inventory (CLEI) (Chan, 2002) and the Clinical Learning Environment Scale (CLES) (Saarikoski & Leino-Kilpi 2002) have been used in studies of students' satisfaction with their clinical learning opportunities. The CLEI examines students' actual and preferred experiences across six domains, personalisation, involvement, task orientation, innovation, individualisation and satisfaction (Chan 2002). Personalisation, a measure of the individual student's opportunity to interact with clinicians or a clinical teacher and attention to the student's welfare have been demonstrated as important for student satisfaction in several studies (HWA 2012, Papathanasiou, Tsaras & Sarafis 2014, Smedley & Morey 2010).

Early studies with the Clinical Learning Environment Scale (CLES) identifying that a positive ward culture and favourable attitude of nurses towards students were important in the perception of a 'good' placement (Saarikoski & Leino-Kilpi (2002). More recently Doyle et al. (2017) using the Clinical Learning Environment Scale plus nurse teacher (CLES+T) in an Australian context found a welcoming workplace, positive approach towards students and staff willing to engage with students continued to contribute to positive experiences. The addition of the nurse teacher (NT) domain in the CLES+T tool, evaluates the impact of a HEI employed NT supporting the student in practice (Saarikoski et al. 2008). Saarikoski et al. (2009) have identified that the nurse teacher's use of communication and interpersonal skills to build relationships with students, was as relevant as their knowledge or clinical skills in promoting student satisfaction.

Several studies have specifically examined the student supervisor experience as their focus (Andrews & Ford 2013, Brammer 2008, Courtney-Pratt et al. 2012, Dickson, Walker & Bourgeois 2006). The needs of student supervisors in a clinical facilitation model were examined by Andrews and Ford (2013). They identified that new facilitators needed orientation to the role, feedback on their performance and exposure to a wider community of practice to share their experiences, considered particularly pertinent given the autonomous nature of the role (Andrews & Ford 2013). When the HEI provides a student supervisor (clinical facilitator), ward nurses play an important role supervising students whilst the clinical facilitator attends other students, yet may have limited choice or preparation for the role. An Australian study (Brammer

2006) established that RN's in this 'buddy' role have varied understandings of their role with the potential to enhance or impede student learning. Reciprocally, Brammer (2008) found student experiences of buddy RN's varied, related to the level of preparedness, engagement and vigilance provided by the ward nurses. Heavy workloads, time constraints and sheer numbers of students on wards influenced the 'buddy' RN's ability to spend time with students (Courtney-Pratt et al. 2012)

In mentorship or preceptorship models of student supervision, were a ward based RN is the student supervisor, barriers to effective supervision include a lack of preparation for the role, extent to which there is recognition and organisational support, and time pressures (Andrews & Ford 2013, Bray & Nettleton 2007, Courtney-Pratt et al. 2012, Myall, Levett-Jones & Lathlean 2008). In Myall, Levett-Jones and Lathlean's (2008) UK study, new mentors felt unprepared for the role and lacked confidence in supporting students despite attending recognised mentor programs. Greater recognition of the role supervisors' play in students' development along with enhanced preparation, ongoing development and effective communication has been recommended (Andrews et al. 2006, Myall, Levett-Jones & Lathlean 2008).

A major challenge for the supervisor-student relationship can be the duality of the role, acting as mentor/facilitator and assessor. With regards to assessment, Jervis and Tilki (2011) identified three challenges, the complexity of assessment, the challenges with assessing attitudes, and having confidence in decision making. In part as a response to this complex issue, the UK has introduced the sign-off mentor (SOMs) as the assessor in student's final placement. Evaluation of this role indicates successful implementation as a robust assessment of competence remains dependent on adequate preparation and dedicated time to ensure the role can be effectively implemented (Barker et al. 2011, Rooke 2014).

1.5.2: Study aim and objectives

The primary aim of the study was to capture the *best of what is* in two differing approaches to the delivery of clinical education, including student supervision, so as to identify key required elements for success. Then to imagine *what could be*, using this vision to inform the design of innovative, meaningful clinical learning experiences for undergraduate nursing students.

The objectives for the study were:

1. Deepen the understanding of the characteristics of undergraduate nurse clinical education models that are conducive to promoting meaningful experiences for students and identify the individual and organisational factors that support and influence them.
2. Appreciatively explore the perceptions of students, academics and professional staff as to what works well and how or why it works well, with particular reference to:
    a. the organisation and implementation of the clinical placement model;
    b. meeting the individualised learning needs of nursing students;
    c. students' progression to becoming nurses;
    d. the provision of student supervision;
    e. structure and duration of clinical placement.
3. Generate insights into potential innovations, new designs or opportunities for undergraduate nurse clinical education, shifting from the location or team bound 'placement' to student clinical learning 'experiences', with reference to:
    a. strategies to best prepare students and supervisors for engagement in clinical experiences;
    b. diversifying and maximising clinical learning opportunities.

This thesis will consider how novel approaches to inquiry and understanding may heighten understanding of the complexities within the provision of the clinical component of nurse education, within and across the varied models that exist.

1.6: Structure and terminology of the thesis

In this thesis, the term *placement* is used to denote an episode of student in situ clinical or practice experience; the number, duration, type and so forth of these experiences are determined by the model of clinical education and aspects of the respective nursing program. The terms *supervisor* and *student supervision* are used, when a generic term is required, to denote the person or role with direct responsibility of supporting, teaching and assessing student nurses. In the UK, this is typically, a nominated *mentor*, who is a ward nurse who has completed an approved mentor preparation program (NMC 2006). In addition, in the UK there are designated and registered *'sign-off' mentors* with additional preparation and accountability to the NMC for a final assessment of a student's eligibility to register as a nurse (NMC 2008). In Australia, a *clinical facilitator* is the most encountered student supervisor. However, in both countries, reference may be made to the RN *buddy*, nurses working with students on a shift or day-to-day basis and also provide student supervision. These forms of student supervision are

distinct from the term clinical supervision used amongst registered practitioners in reference to the establishment of a peer reflection, review and support process (Bifarin & Stonehouse 2017).

To address these aims and objectives of this study, the following section briefly presents an overview of the thesis to follow by outlining the subsequent chapters and their content.

Chapter Two - Literature Review

Chapter Two presents an integrative literature review that aimed to identify if a preferred mode for clinical education exists. Studies that compared or contrasted differing models of clinical education and/or models of student supervision were included. The review did not identify a single approach or model of clinical education as preferable over others. Instead, the review identified that common features, evident within differing approaches to clinical education provision, were essential for meaningful experiences. The review highlighted the importance of interpersonal relationships; the need for consistency in the implementation of the education model, the potential for a variety of models to exist related to the requirements in differing clinical settings and the need to sustain the viability of the models' implementation. The review of the literature concludes by acknowledging that the core elements that emerge within and across education models as a whole, may inform best practice in the provision of meaningful experiences for students.

Chapter Three - Frameworks, Research Design and Methods Research Design

The research design, including an examination of the theoretical perspective of constructivism and case study as a methodology, is presented in Chapter Three. The design and conduct of the study were guided by elements of appreciative inquiry, which as a research philosophy shifts inquiry from a problem-based, to a strengths-based approach, to identify the *best of what is* and *what could be*.

The settings for the study are two universities, one in the UK and one in Australia. An overview of the structure and governance of nurse education in each country is presented, as are the features of the clinical component at each site. This assists in contextualising the findings and provides a basis for the commentary in the discussion chapter. In addition, the chapter describes the sample, the methods adopted, including the use of questionnaire and semi-structured interview; the approaches to data analysis, and ethical considerations.

Chapters Four, Five and Six - Findings

The findings from the thematic analysis and cross case synthesis of questionnaire and interview data are presented in Chapters Four, Five and Six. In Chapter Four, the student voice predominates and the themes that emerge centre on the individual student experience of engagement with learning in the clinical setting. Chapter Five focuses on the structure and delivery of the clinical education model, at an organisational level, balancing the staff and student perspectives. Evident in the themes are the complex frameworks that support clinical placement provision and interconnections between and across the educational and healthcare sectors. In Chapter Five, findings related to the structure and duration of placements are presented. In the final findings chapter, Chapter Six, the wider professional and social context that influences undergraduate nurse clinical education is collated. The perspectives in Chapter Six are solely these of the academic and professional staff from the two study sites.

Quotes from the participants are incorporated throughout each of the findings chapters to promote integrity and enrich the presentation of the findings.

Chapter Seven – Discussion

In the discussion chapter, Chapter Seven, the findings are framed by adopting a conceptual framework, based on Bronfenbrenner's Ecological Systems Theory of Development Model (1977) as a means to visualise the complex layers and interconnections required for meaningful clinical placement experience provision and the context within which these occur. In addition, elements of complex adaptive systems theory provide a means to explore some of the inherent features of clinical learning experiences such as the inherent unpredictability, yet within which pattern driven elements of clinical learning experiences are evident. The findings are considered in the context of existing knowledge and literature.

Chapter Eight – Conclusion and Recommendations

The conclusions drawn from this study are offered in Chapter Eight. A series of recommendations are presented that relate to the theoretical and practical understanding of clinical learning experience provision, which may inform future educational design. The strength and limitations of the program of research presented in this thesis are also given along with areas for further research to continue the dialogue and inquiry in this field.

1.7: Chapter summary

The preface has established the personal impetus and professional interest in undergraduate nurse clinical education to provide a gateway into the thesis. In this introductory chapter, a wider exploration of the context and background to the doctoral study has been presented. Central to this are the perceived challenges, both past and present that influence the current provision of clinical education. However, also of note is the emergence of innovative solutions to address ongoing delivery of in situ clinical learning experiences.

From this basis, the conceptualisation of this study was developed to examine the perspectives of higher education staff and final year students at two universities, in relation to the provision of meaningful clinical experiences. The chapter draws to a close by establishing the main research aim and research questions. Finally, a final brief synopsis of each chapter has been presented to act as a navigational guide to the remainder of the thesis, which continues with the literature review.

CHAPTER TWO: LITERATURE REVIEW

'…there is always a well-known solution to every human problem — neat, plausible, and wrong'

H.L.Mencken[6]

2.1: Introduction

The body of literature pertaining to undergraduate nurse clinical education is vast and diverse, examining an extensive range of elements including student supervision, the student experience, student assessment and the transition from learner to registered practitioner. Despite the richness of this literature, the question as to whether there is there an optimal approach to undergraduate clinical education for nursing remains unanswered. Yet, given the layers of complexity in the provision of clinical experiences, there is scope to move towards a deeper and more nuanced understanding of what constitutes elements of best practice in the provision of clinical experience, regardless of the overarching model.

The literature review sought to determine whether an optimal model for clinical education existed. If one was not identified, the secondary question was to establish what factors promote successful clinical experiences, regardless of model. In addition, the methodological approach taken to compare models of clinical education was examined to inform innovative ways in which to research across divergent models of clinical education. These questions were designed to add to what is already known about the creation of meaningful, positive clinical learning experiences to inform best practice.

The literature review presented in this chapter is an edited and adapted version of a published manuscript[7] (Appendix 1). The review examines published studies which had compared or contrasted models of clinical education, including models of student supervision and identifies that an optimal model for clinical education does not emerge. The review, however, highlights the factors associated with the effective provision of meaningful clinical learning experiences.

2.3: Background to the literature review

Clinical learning experiences are a vital component of undergraduate or pre-registration nurse education programs (Mannix et al. 2006). Global demand for new nurses to replace an aging

[6] 'Explanations exist; they have existed for all time; there is always a well-known solution to every human problem — neat, plausible, and wrong.' H.L. Mencken (1920) in Prejudices: Second Series

[7] Forber, J, DiGiacomo, M, Carter, B, Davidson, P, Phillips, J, & Jackson, D 2016, 'In pursuit of an optimal model of undergraduate nurse clinical education: An integrative review', *Nurse Education in Practice*, Vol. 21, pp. 83-92.

workforce and supply the growing healthcare sector is placing unprecedented demand on sourcing clinical learning experiences. Concurrently, the introduction of non-registered healthcare workers' roles results in fewer registered nurses to supervise students (Hasson, McKenna & Keeney 2013a). Hence, there is re-vitalised interest in determining effective, sustainable options for clinical learning experiences and student supervision (Cross 2009; Jackson & Watson 2011). As clinical education is being increasingly scrutinised, exploring the evaluation of clinical education models is opportune (Willis 2012).

Various approaches exist for the provision of clinical learning experiences. There are multiple practice education or supervision models (Budgen & Gamroth 2008; HWA 2012) and the wide-range of clinical settings, patients, staff and supervisors each student encounters, all influence learning opportunities (Papp, Markkanen & Bonsdorff 2003). Further compounding this diversity is a lack of unified terminology, making it challenging to compare and contrast the differing clinical education models.

Enhanced understanding of the elements contributing to positive learning experiences is needed to best prepare students for the challenges of the health care workforce. Factors known to promote quality learning experiences for students include feeling that they are welcome, they belong, are valued as learners and can contribute to the healthcare team (Bradbury-Jones, Sambrook & Irvine 2007; Levett-Jones et al. 2007). Also, crucial is the development of supportive relationships between students, staff and supervisors (Myall, Levett-Jones & Lathlean 2008; Saarikoski, Leino-Kilpi & Warne 2002). Sufficient learning opportunities, adequate student and supervisor preparation and sufficient support for supervisors are further key elements (Courtney-Pratt et al. 2012).

Despite this awareness, quality clinical experiences do not always eventuate (Brown et al. 2011; Nielsen et al. 2013; Willis 2012). Poor quality placements and unsatisfactory learning experiences are reported (Andrews et al. 2006; Brown et al. 2011; Ip & Chan 2005) and may influence attrition from undergraduate nurse education programs (Crombie et al. 2013; Eick, Williamson & Heath 2012). This literature review sought to identify if there was an optimal model of clinical education and/or student supervision which maximised learning outcomes. In addition, an exploration of the methodological approaches taken to evaluate differing models within the included studies would inform the design of the current research study

2.4: Aim

The overall aim of this integrative review was to identify, describe and critically review studies that from the student perspective compared or contrasted clinical education models, including models of student supervision, within undergraduate nursing programs.

Objectives

The two main review objectives were to:

- Describe the methodological approaches taken in each study and consider if any challenges were encountered, and
- Integrate the findings from the studies to inform understanding of undergraduate nurse clinical education and establish if an optimal model(s) emerged.

2.5: Methods

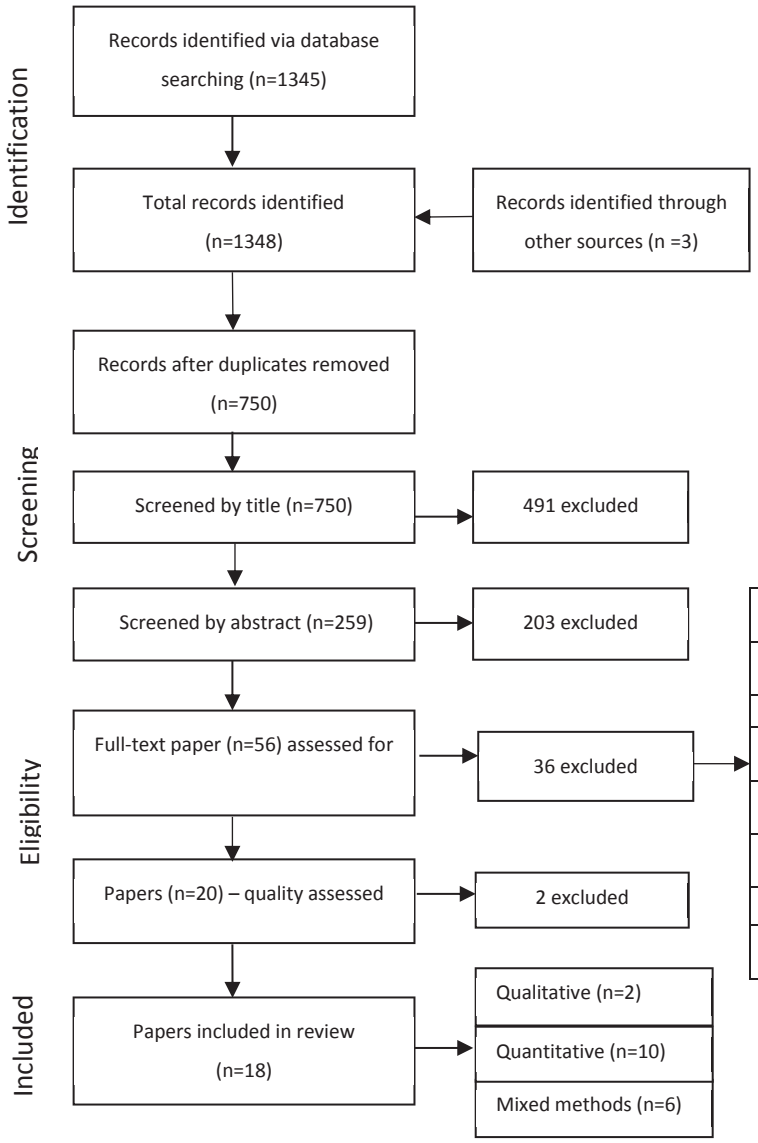
2.5.1: Search Methods

An integrative review using a systematic approach was employed. This review method supports simultaneous inclusion and examination of varied methodologies generating a comprehensive approach to address the objectives of this review (Whittemore and Knafl, 2005). The literature search was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis checklist - PRISMA (Moher et al. 2009). Eight electronic databases were searched: Academic Search Complete, CINAHL, Medline Ovid, ProQuest Health and Medical, Scopus, PsychInfo plus the Joanna Briggs Institute EBP Database and Cochrane Library. Hand searching of nurse education journals and references lists of included papers was undertaken. The search terms were: clinical education, practice education, practice learning, clinical learning environment and undergraduate, student, pre-registration and model/models, nurs*, nursing, nurse. In order to capture studies investigating contemporary curricula the search was limited to 10 years from the initial search, Jan 2006-Dec 2015. Inclusion criteria were: 1) English language; 2) peer-reviewed; 3) compared models of undergraduate clinical education/student supervision; and 4) participants were preparatory nurse education program students. Papers were excluded if they were: 1) editorials, opinion pieces, or conference abstracts; 2) review papers; or 3) not written in the English language.

2.5.2: Search outcome

Figure 2.1 presents the process to screen, evaluate and eliminate non-eligible papers; 56 papers were considered eligible for full review and 36 papers were eliminated for the reasons indicated. A further two were eliminated after quality appraisal resulting in a total of 18 papers included in the review.

Figure 2.1: PRISMA Flow Chart



Reason	No.
Focus on one model and/or no specific intent to compare/contrast models	18
Papers are descriptive, implementation or non-research based paper	9
Not specifically related to undergraduate clinical education/supervision models	5
Participants are preceptors, education/clinical staff, recent graduates	2
Mentors' views of student supervision	1
Administrative/support systems for supervisors	1

2.5.3: Quality Appraisal

Twenty papers were appraised using a framework supporting quality assessment across various methodologies (Hawker et al. 2002). Quality appraisal included, determining the congruency between aim and methodology, appraising the data analysis, presentation of findings, discussion and ethical considerations. Neither sample size nor population was appraised given the diversity across studies. Two studies were excluded. The first (Moscato et al. 2007) presented an

informative, yet descriptive account of the implementation of a clinical education model. The second lacked methodological detail, such as the recruitment processes (Hendricks et al. 2013). The final review comprised 18 papers (Table 2.1).

2.5.4: Data extraction and synthesis

A two phase data extraction process was undertaken. Firstly a matrix was created to collate the various study designs, methods, objectives and study populations in order to describe the studies in the review. Second, the findings from each paper were extracted and organised under two main fields; the model of clinical education or model of student supervision the finding was attributed to. These data were then coded inductively into categories as described by Miles, Huberman and Saldana (2015) that transcended the models of education or supervision. Data comparison then followed an iterative process to identify potential patterns, themes or relationships across the data (Whittemore & Knafl 2005). Initial themes were reviewed and refined to capture the essence of each theme, which was then defined and named (Braun and Clarke 2006).

2.6: Results of the review

The findings from this review are presented in three sections: 1) the characteristics of the studies, 2) a summary of findings from the studies, tabulated under broad clinical education/supervision model headings; and 3) the emergent themes which transcended the models under investigation.

2.6.1: The Characteristics of the Studies

Overview of included studies

The included 18 papers, reporting 15 studies, are presented in Table 2.1. The majority of papers (n=7) originated from Australia; including five from Queensland ,(Henderson, Beattie, et al. 2006; Henderson, Heel, et al. 2006; Henderson, Twentyman & Heel 2006; Nash, Lemcke & Sacre 2009; Walker et al. 2013), and one each in New South Wales (Croxon & Maginnis 2009), and Victoria (Newton et al. 2012b). Of the Queensland papers, the three Henderson et al. (2006) papers report findings from one larger project. The remaining studies were predominantly from the United States of America (Lovecchio & Hudacek 2012; Mulready-Shick, Flanagan, Banister, Mylott, et al. 2013; Nishioka et al. 2014; Smyer et al.), Europe (Gustafsson et al. 2015; Hellström-Hyson, Mårtensson & Kristofferzon 2012; Roxburgh 2014b; Sundler et al. 2014b; Warne et al. 2010) plus studies from Iran (Parchebafieh et al. 2014) and Saudi Arabia (Omer et al. 2013).

Table 2.1: Included papers - presented alphabetically (N=18)

Author (Year)	Location	Study objective	Study design, participants, data	Methods	Direct or indirect [a]	Education/supervision models in the study[b]			
						Trad.	**Prec.**	**CEU+**	**Other**
Croxon & Maginnis 2009	Australia	Student experiences, achieving learning objectives, practicing clinical skills, availability/support by preceptor/ clinical facilitator.	Mixed methodology, 2nd year BN students (n=20). Single site.	Questionnaire Likert scale & open-ended questions.	Direct		Y		Cluster
Gustafsson et al. 2015	Sweden	Student perceptions of nurse teacher role in 2 differing models.	Mixed methodology, 3rd year students (n=114), Model A – University nurse teacher n=53, Model B Clinical nurse teacher n=61. Interviews n=8.	Interviews and CLES+T (Clinical Learning Environment Supervision + Nurse Teacher scale).	Indirect				Y
Hellstrom-Hyson et al. 2012	Sweden	Student experiences 2 supervision models. Seven week traditional placement and 2 weeks student ward.	Descriptive qualitative study, final semester students (n=8).	Semi-structured interviews.	Direct	Y			Y
Henderson, Beattie et al. 2006*	Australia	Student's perceptions of psycho-social characteristics of clinical learning environment in 2 models.	Survey design. 1st year students, n=33, traditional model and n=31, collaborative education unit (CEU) model.	Survey using Clinical Learning Environment Inventory (CLEI)	Indirect	Y		Y	
Henderson, Heel et al. 2006*	Australia	Student's perceptions of psycho-social learning environments with 2 models.	Pre-test/post-test quasi experimental design. 2nd & 3rd years. Pre-test, n=370 traditional model. Post-test n= 287 traditional model and n= 83 CEU model.	Survey using CLEI.	Direct in intervention group	Y		Y	
Henderson, Twentyman et al. 2006*[8]	Australia	Student's perceptions of psycho-social characteristics of the clinical learning environment in 3 models.	Survey design. 1st, 2nd, 3rd year students, n=399. Year 1 n=34 traditional model, year 2 n=50 CEU and n=156 traditional, Year 3 n=64 CEU, n=79 traditional, & n=16 preceptorship	Survey using CLEI.	Indirect/ direct	Y	Y	Y	
Lovecchio et al. 2012	USA	Student's clinical experiences of 2 models -modified Dedicated Education Unit (DEU) with Clinical Liaison Nurse (CLN) & traditional model.	Quasi experiment: post-test only, non-equivalent control group. Junior & senior students. Convenience sample n=40 experimental group and n=14 traditional model.	Survey using CLEI.	Indirect	Y			CLN
Mulready-Shick et al. 2013	USA	Whether DEU model enhances educational quality i.e. experience, clinical learning and quality & safety competency.	Evaluation study, students randomly allocated to two models. Junior students - n=111 DEU and n=54 Traditional model.	Surveys - Student Evaluation of Clinical Education Environment (SECEE), 2 authors developed surveys & student assessments	Indirect/ direct	Y		Y	
Nash et al. 2009	Australia	Experiences specific to transition, enhanced DEU model and traditional model.	Mixed methods, pre/post-test survey, final year students, n=92. Transition project model n=29, traditional model n=63. Focus groups n=15	Survey and focus groups.	Direct	Y	Y		

[8] * Henderson, Beattie et al. 2006, Henderson, Heel et al. 2006 and Henderson, Twentyman et al. 2006 papers relate to the same overall study.

Author (Year)	**Location**	**Study objective**	**Study design, participants, data**	**Methods**	**Direct or indirect** [a]	**Education/supervision models in the study**[b]			
						Trad.	**Prec.**	**CEU+**	**Other**
Newton et al. 2012	Australia	Student experiences of 2 models. **MASH** a tertiary industry collaborative model, underpinned by preceptorship – students assigned home base, preceptor and constant clinical teacher.	Longitudinal quantitative study. 2nd & 3rd year students. Traditional model, clinical teacher n=194, traditional model, clinical teacher and preceptor n=165, & MASH model, clinical teacher and preceptor n=97.	Surveys - modified Clinical Learning Environment Inventory (CLEI). Component of larger study	Indirect		Y	Y	
Nishioka et al. 2014	USA	Student perceptions of 2 clinical education models	Repeated measures design, junior and senior baccalaureate & masters students. 6 focus groups: n=32. Surveys 473 students, returning 2-4 surveys (n=1053).	Focus groups and CLES+T (Clinical Learning Environment Supervision + Nurse Teacher scale).	Direct	Y		Y	
Omer et al. 2013	Saudi Arabia	Student perceptions of two models of Preceptorship. **An** education employed preceptor, allocated 2 patients and 4 students. ***B*** ward nurse allocated 6-7 patients and 1 student.	A descriptive, exploratory, quantitative survey study. Model A n=57 in Adult wards, Model B n=53 on maternity and paediatrics	Surveys. Moore's Preceptorship Evaluation Survey (PES).	Indirect/ direct	Y	Y		
Parchebafieh et al. 2014	Iran	Effectiveness of the Clinical Teaching Associate (CTA) model (seconded ward RN supervising students) on clinical learning outcomes/student satisfaction.	Randomised controlled trial intervention and control groups. Year 3 students, n=28 CTA group & n=32 control group traditional model.	Student satisfaction questionnaire, written exam and summative assessment.		Y			CTA model
Roxburgh 2014	UK	Student perceptions of two Clinical Education Models.	Qualitative part of larger study. 2nd year students (n=10 adult program).	Focus groups.	Direct	Y			Hub & Spoke
Smyer et al. 2015	USA	Differences in academic outcomes between students in a DEU and a traditional model	Longitudinal quasi-experimental repeated measure design, n=144. DEU n=90, traditional n=54.	The Health Education System Inc. (HESI) exams – as baseline, , post clinical and on RN exit	Indirect	Y		Y	
Sundler et al. 2014	Sweden	Student experiences of clinical learning environment related to supervision	Mixed methods, cross sectional study. Final year students at 3 universities Convenience sample n= 185 students. Personal preceptor only n=54, several personal preceptors n=107 and patient room with numerous preceptors n=24	Survey CLES+T (Swedish version) + 1 open-ended question.	Indirect		Y		patient rooms
Walker et al. 2013	Australia	Student's perceptions of support two models of supervision	Cross sectional qualitative & quantitative study. Participants across three years BN (purposive sample n=159).	Author(s) developed online survey. 22 closed and 3 open items.	Indirect	Y	Y		
Warne et al. 2010	Multiple	Factors enhancing student experiences in clinical practice.	Quantitative Survey design. Pre-registration students at 7 polytechnics and 10 university colleges across nine countries (n=1903).	Survey. Validated CLES+T translated into various languages.	Indirect	Varied			

[a] 'direct' participants experience two or more models of clinical education/supervision, 'indirect', two cohorts of participants but each experienced only one model. [b] Education or supervision models included: Trad = Traditional, Prec = Preceptorship or mentorship model – (NB: MASH = an acronym constructed from the names of the university and healthcare organisation concerned), CEU+ = Collaborative Education Unit, Dedicated Education Unit models or other partnership based models, Other = models not in other categories.

The duration of clinical placements varied, ranging from 32 hours (Parchebafieh et al. 2014) to 42 weeks (mean 6.4 weeks) in Warne et al.'s (2010) study. Students at various stages of their progression are represented and clinical settings range from single site, single speciality studies (Hellström-Hyson, Mårtensson & Kristofferzon 2012) to single site, multiple speciality studies (Omer et al. 2013). The study approach could be considered *direct* where participants experienced two or more models of clinical education/supervision, and therefore were able to draw from contrasting experiences or *indirect*, were each cohort of participants only experience one model under investigation.

Study design, study objectives and data collection methods

Half (n=9) of the studies used validated survey/questionnaires with five studies using the Clinical Learning Environment Inventory (CLEI) scale (Henderson, Beattie, et al. 2006; Henderson, Heel, et al. 2006; Henderson, Twentyman & Heel 2006; Lovecchio & Hudacek 2012; Newton et al. 2012b), while four used the Clinical Learning Environment Supervision and Nurse Teacher (CLES+T) (Gustafsson et al. 2015; Nishioka et al. 2014; Sundler et al. 2014b; Warne et al. 2010). Developed by Chan (2002) the CLEI scale evaluates six domains; individualisation, innovation, satisfaction, involvement, personalisation and task orientation. The original CLES scale (Saarikoski & Leino-Kilpi 2002) has five sub-dimensions; ward atmosphere, leadership style of the ward manager, premises of nursing care, premises of learning on the ward and supervisory relationship. The dimension of nurse teacher in clinical practice (CLES+T) was added subsequently (Saarikoski et al., 2008).

The outcome measures centre on student experiences or perceptions of clinical education and consequently, this review presents a student-centric view. Seven studies (Croxon & Maginnis 2009; Gustafsson et al. 2015; Hellström-Hyson, Mårtensson & Kristofferzon 2012; Omer et al. 2013; Parchebafieh et al. 2014; Sundler et al. 2014b; Walker et al. 2013) focus on student experiences of supervision models. Whereas, Lovecchio & Hudacek (2012), Newton et al. (2012b), Nishioka et al. (2014), Roxburgh (2014b) and Mulready-Shick, Flanagan, Banister, Mylott, et al. (2013) endeavour to explore the overall model of clinical education. Nash, Lemcke & Sacre (2009) specifically compares two forms of transition placement for final year students. Few studies endeavour to measure learning outcomes or competency attainment, however Mulready-Shick et al. (2013) include student grades and exam results, while Parchebafieh et al. (2014) consider knowledge acquisition and Smyer et al.'s (2015) outcome measure is academic performance.

Methodological challenges identified by study authors

All but four studies explicitly consider the challenges or limitations within their research, which consisted of numerous contextual variables including: program duration, stage of student progression, variety of clinical settings, size of facility, supervisor experience, participants' prior experiences and personal characteristics. For example, Henderson, Twentyman & Heel (2006) question if the perceived 'excitement' of some wards influences student evaluation of their experience. Gustafsson et al. (2015) commented on the potential methodological constraints afforded by the many stakeholders involved in the provision of clinical education. Finally, small overall sample size and limited sub-group numbers in study populations was acknowledged by Roxburgh (2014), Henderson et al. (2006c) and Lovecchio & Hudacek (2012). In the Parchebafieh et al. (2014) randomised control trial small sample size was noted this as a potential impact on the statistical ability to differentiate between study groups.

2.6.2: Summary of findings from the included studies, organised under broad clinical education/supervision model headings

Whilst terminology varied, clinical education or supervision models essentially fell into three main groups plus the several novel alternatives as described below. Given local variation and contextual constraints, whilst these headings create a review framework to explore the findings, they are neither discrete nor exclusive. Tables 2.2a and 2.2b summarise the key findings utilising these models as a guide.

Terminology

The traditional model (or block or rotational placement model)

The traditional model (or block or rotational placement model) centres on an education sector funded clinical facilitator (or *faculty*) as primary instructor for a group of (typically eight) students across several wards/units, with students 'buddied' with registered nurses each day (Courtney-Pratt et al. 2012). As each placement may be in a different ward or facility this creates the rotational aspect. The cluster model variant, co-locates students on one ward/unit, affording increased clinical facilitator contact and peer support (Croxon & Maginnis 2009).

The preceptorship model (or mentorship model)

The central tenet of the preceptorship model (or mentorship model) is a 1:1 supervisory relationship between student and health facility employed RN; with Warne et al. (2010) observing trends towards such models. Preceptorship needs sufficient time and support to function and is impacted by staff shortages and busyness of the clinical setting (Walker et al.

2013). Mechanisms of support for the preceptorship model may be incorporated into the model, as Gustafsson et al. (2015) explore in their focus on a clinical teacher role.

Collaborative models (or partnership models and Dedicated Education Units)

Collaborative models (or partnership models and Dedicated Education Units) are underpinned by education-industry collaboration with the majority or all student placements occurring in one healthcare organisation and all staff engaging in teaching and support. The implementation, constancy and sustainability of collaborative models require commitment from both parties. These models aim to promote student welfare and individual learning (Forbat & Henderson 2005; Henderson, Beattie, et al. 2006; Henderson, Heel, et al. 2006) and generate 'real world' experiences for students.

Other models: Hub and Spoke model, student wards

In Hub and Spoke models, students belong to a 'hub' facility, with a series of 'spoke' experiences away from the main hub to develop understanding of the patient journey and care pathways (Roxburgh 2014b). In student ward models, students work in pairs and are jointly responsible for four patients (Hellström-Hyson, Mårtensson & Kristofferzon 2012). Under supervision, the student ward promotes collaboration, shared learning, continuity and patient engagement promoting greater independence in care delivery.

2.6.3: Findings from this review - emergent themes which transcended the models under investigation.

Despite the diverse approaches to clinical education or supervision within this review, several themes emerged and transcended any particular model.

The central role of interpersonal relationships

The significance of interpersonal relationships influencing students' satisfaction within the clinical learning environment has been consistently demonstrated in the wider literature (Papastavrou et al. 2010; Saarikoski et al. 2008). In this review the importance of relationships was demonstrated across the various models studied. Warne et al.'s (2010) large scale study, amongst others, correlates the quality of the supervisory relationship and student satisfaction with clinical experiences. It may be expected that differing forms of supervisory relationship offer their own particular strengths and this was demonstrated in several studies. Gustafsson et al. (2015) examined student experiences of support received from nurse teachers. When nurse teachers were employed directly by the healthcare care facility, their connectedness to clinical

Tables 2.2a and 2.2b Summary of key findings

Table 2.2a: Findings related to the education or supervision models in each paper: Traditional and Collaborative Education Unit (CEU) models

Author (Year)	General findings	Specific Findings for Models Studied	
		Traditional	**Collaborative Education Units**
Henderson et al. 2006a	Satisfaction high for both models.	Traditional	The Clinical Learning Environment inventory (CLEI) scores higher for collaborative model, only significant for the *personalisation*. Indicative of greater concern for student welfare/learning.
Henderson et al. 2006b	High levels of satisfaction in existence already, prior to the Introduction of a collaborative model.	Traditional	Collaborative model significant differences post-test for *student involvement, satisfaction, personalisation and task orientation.* Indicative student's unique learning needs addressed.
Lovecchio et al. 2012	Supportive of academic–practice partnerships for clinical learning	Traditional	Preference for Clinical Liaison Nurse model (CLN), statistically significant for the CLEI domains - *task orientation, satisfaction and individualisation*. Indicative benefit of students working with clinical staff plus faculty member.
Mulready-Shick et al. 2013	Both groups reported positive clinical experiences.	Traditional	DEU - significantly more positive learning experiences. Greater time spent in instructional activities, engaged with patient care and higher supervision quality. No impact overall on academic performance.
Nash et al. 2009	Scope for differing transition placements that suit student's learning style/needs.	Traditional -participants in either model more prepared to transition to RN role.	Trend towards students being more prepared but not significant. Benefits - experiencing the 'real world', a realistic shift pattern, team work & understanding of learning needs.
Newton et al. 2012	Student centeredness key aspect of positive learning environments	Traditional	MASH model more positive for CLEI factor of *student centeredness* - highlights clinical teacher role important for continuity & relationship development.
Nishioka et al. 2014	Both models valued – learn discreet skills in traditional model and 'nursing' in DEU.	Traditional - quality of learning unpredictable, lack of time with faculty member, RN engagement with, operational and communication structures created barriers to effective education, ambiguous roles and unwelcoming wards.	Dedicated Education Unit – treated as a nurse not a student, less left to chance. Overall DEU's more conducive to learning – clearer leadership, welcoming atmosphere, individualisation and commitment to teaching.
Smyer 2015	No significant differences between DEU and Traditional model student scores on academic outcome measures (HESI scores)	Traditional	Dedicated Education Unit – students were considered not to be advantaged or disadvantaged academically by the implementation of the DEU model. Students only participated in the DEU model once so the authors question if differences may emerge with greater exposure.

Table 2.2b: Findings related to the education or supervision models in each paper: Traditional, preceptorship and other alternate models

Author (Year)	General findings	Specific Findings for Models Studied	
		Traditional	**Other model(s)**
Croxon & Maginnis 2009	Both models supported 'hands on' practice & improved confidence.	May suit 'quiet' students. Preceptors require sufficient time for role.	**Cluster model:** increased availability and time from the clinical facilitator. Provides peer support.
Gustafsson et al. 2015	The two models have different strengths.		**Preceptorship with either a University employed nurse teacher (UNT) OR a healthcare/clinical employed nurse teacher (CNT).** CNT's had greater ability linking theory to practice and their connectedness to clinical practice was an advantage. UNT's were considered knowledgeable and supportive especially if students had, for example, conflicts with their preceptor.
Hellstrom-Hyson et al. 2012		When 'buddied' with RN, students feel like a 'helper', unable to see overall context and lacked control over patient care.	**Student wards** - in pair's student collaborate to problem solve, organise care delivery and develop independence. Sense of continuity, engagement with patient care.
Henderson et al. 2006c	Final year students need longer placements and time for integration.	Traditional	**Preceptorship and Collaborative Education Unit**: Preceptorship preferred for enhanced student engagement (NB small sample size), mirroring the real expectations of the RN. CEU - higher CLEI scores but only significant for *personalisation*
Omer et al. 2013	Preparation required to move between varying supervision models.	Education provider funded Clinical Teaching Assistant (novel model here). Increased student satisfaction - improved teaching, role modelling and learning.	**A pre-existing preceptor model** - RN with full patient load supervising 1 student. Used in specialist areas e.g. Paediatrics. Limited supervisory support/student advocacy.
Parchebafieh et al. 2014	Overall satisfaction the same. Both effective enhancing knowledge/ clinical skills.	Traditional, students found the faculty member promoted linking theory to practice.	**Clinical teaching associate model** (adapted Preceptorship) effective for learning patient communication and skills. Potential for collaboration between education and health partners
Roxburgh 2014	Overall, preference for mixed model hub & spoke and traditional.	Rotational aspect creates anxiety, impacts student's belonging, acceptance as team member, and continuity in learning / development.	**Hub and Spoke model** - students had sense of belonging (aligned to, geographical location, role models and understanding care pathways). Developed lasting confidence.
Sundler et al. 2014	Overall, students had positive experiences of the clinical learning environments	CLES+T domains *supervisory relationship and pedagogical atmosphere* rated significantly greater for preceptorship model. Continuity/quality of supervision emphasised.	**Student training rooms** - dissatisfaction linked to multiple supervisors, issues with attitudes, continuity and 'pitching' supervision at the right level.
Walker et al. 2013	Quality of student support matters most, not the model. Both having merit.	Traditional group supervision – preferred. Participants significantly more likely to agree facilitators challenged thinking & problem solving via reflection, built on existing knowledge/skills.	**Preceptorship model** - potential for too many preceptors due to staff shortages and busyness of the clinical environment.
Warne et al. 2010	Participants in general were satisfied with their clinical placements.		**Multiple options** over 9 countries: Overall, students evaluated clinical experiences positively, particularly for CLES domains *supervisory relationships and pedagogical atmosphere*. Longer placements associated with greater satisfaction. Most important factor in satisfaction was supervisory relationships.

practice was an advantage in ensuring they were well informed about day-to-day *in situ* practice. In collaborative models, ensuring student integration into the nursing team promotes student engagement with the learning environment (Henderson, Heel, et al. 2006; Lovecchio & Hudacek 2012; Newton et al. 2012b). This is also evident in the study by Nishioka et al. (2014) study where the supervising RN's relationship with the facility, unit and patients promoted a positive, welcoming, personalised learning environment for students, with a consistent commitment to teaching. However, Hellström-Hyson, Mårtensson & Kristofferzon (2012 p.109) warn of a potential 'novelty' effect, which may influence findings related to relationships, whereby early adopters of innovation are those inherently motivated to host and nurture students (Henderson, Heel, et al. 2006; Nishioka et al. 2014). Lovecchio, DiMattio & Hudacek (2012 p.611) agree as settings adopting their Clinical Liaison Nurse model were "historically welcoming and helpful".

In traditional models, the clinical facilitator has a close relationship with the education provider and connection to curricula and students stage of development. Gustafsson et al. (2015) found university employed clinical teachers had sound theoretical knowledge and were able to provide 'neutral' support for students due to their indirect link to clinical areas. Walker et al. (2013) found facilitators can encourage problem solving, reflection and linking theory to practice, as did Parchebafieh et al. (2014) though there are many contextual differences observed in the studies with the latter notably having the shortest duration of placement in the included studies.

Consistency and continuity in clinical education delivery

Nishioka et al. (2014) found models must be consistently defined and implemented to be effective, including establishing key roles and pathways for successful communication. In studies of collaborative models, consistency is important in the underlying philosophy which is evidenced in staff's consistent approach to welcoming, engaging and teaching students (Mulready-Shick, Flanagan, Banister, Mylott. L., et al. 2013; Nishioka et al. 2014).

A consistent supervisor or contact person who understands and monitors students' knowledge, abilities and skill level stimulates student learning and development (Newton et al. 2012a; Sundler et al. 2014a). In Newton et al.'s (2012a) collaborative model, a clinical teacher provided a consistent point of contact resulting in statistically significantly CLEI scores for 'student centeredness' compared to the traditional model. In contrast, Roxburgh (2014a, p43) found students in a traditional rotational model, describing *'*going backwards' or starting again as they moved through placements. Disrupted continuity resulting from multiple supervisors can be a notable cause for student dissatisfaction with clinical experiences (Sundler et al. 2014a).

An important, yet under explored, aspect of clinical placement is related to placement duration. Warne et al. (2010) identified a link between the duration of clinical placements and greater student satisfaction. In longer placements students can develop effective, individualised supervisory relationships and therapeutic relationships with patients. In relation to placement duration, Roxburgh (2014) questions how much time is required to develop the student–supervisor relationship, so that an informed assessment of the student can take place. Hellström-Hyson, Mårtensson & Kristofferzon (2012) argue that to fully understand contextual continuity in care delivery students need to spend sufficient time with patients and have appropriate periods of reflection. The study findings, though inconclusive as to what an optimal duration may be, do suggest that short placements could potentially be of insufficient duration to achieve satisfactory outcomes and effective student assessment.

Opportunity for varied clinical education/supervision models

Many of the studies in this review where students were able to directly report their experiences of two or more models of clinical education, concluded the various models could offer differing advantages for students and/or the clinical settings (Croxon & Maginnis 2009; Henderson, Beattie, et al. 2006; Nash, Lemcke & Sacre 2009; Nishioka et al. 2014; Roxburgh 2014b; Walker et al. 2013). Croxon & Maginnis (2009) found preceptorship and cluster models both supported 'hands on' practice and developed student confidence. The Clinical Teaching Associate model promoted opportunities for patient communication and skill acquisition, with the traditional model linking theory to practice. The students in Roxburgh's (2014b) study proposed a hybrid model: Hub and Spoke placements in year one and three to offer structure and support with a traditional rotational model in year two, to offer varied experiences.

A mix of junior and senior students were repeatedly surveyed in a study by Nishioka et al. (2014) over the duration of their study program and their findings identified that students' learning, developmental and support needs varied over time. Hence, traditional models may benefit beginning students to develop discrete skills under clinical facilitator guidance (Nishioka et al. 2014). In contrast, focussing on the transition into practice as a graduate nurse, Nash et al. (2009) reported that the final year students in their study wanted to experience reality, rostered shifts, patient load and time management afforded in collaborative models. Nishioka et al. (2014) stated that DEU students described learning 'nursing' as opposed to the perceived skill development focus of traditional models. Consideration of clinical settings is also required, as areas with limited capacity

to host students may find preceptorship style models most practical to implement (Henderson, Twentyman & Heel 2006). Omer et al. (2013) suggest differing models can co-exist; however, students need adequate preparation to be receptive to the benefits each offer.

Though a mixed clinical education model may be challenging to integrate into an overall undergraduate nursing program such an approach may address individual learning styles, the needs of differing clinical areas and support student progression over time to achieve requisite outcomes. Smyer et al. (2015) compared academic outcomes in students experiencing a dedicated education unit (DEU) instead of a traditional model placement. Whilst no significant differences were found, Smyer et al. (2015) concede that as students only experienced a DEU once, there may not have been sufficient exposure to generate an effect so students were neither advantaged nor disadvantaged. Nash et al.'s (2009) study also reported no significant difference in the models in their study but noted students electing to participate in an enhanced final transition placement were those more likely to access potentially enriching experiences. Individual preferred learning styles require consideration when considering the outcomes in relation to preferred education models.

Ensuring viability

Whether a clinical education or supervision model can be implemented and supported as intended was the next major theme to emerge from this review. The viability of a preceptorship model's 1:1, (RN:student) relationship can be undermined by staff shortages and busyness of the clinical unit, resulting in students having multiple preceptors (Walker et al. 2013). Similarly, Croxon & Maginnis (2009) concluded a preference for their new cluster model, however, staff shortages and workload issues had prevented the pre-existing preceptor model's functional viability. Hence, no matter how innovative and well received a new model may be initially, its evaluation and ongoing viability over time becomes critical.

The willingness to embrace a new model is another issue. Nishioka et al. (2014) had ward personnel volunteer their wards for the new DEU format and suggest positive outcomes may not have been achieved if sites had been involuntarily assigned the new model. Finally, students, supervisors and others must be adequately oriented and resourced to engage, as intended, to promote the viability of any model (Omer et al. 2013).

2.7: Discussion

The diversity inherent within the clinically based component of undergraduate nurse education is exemplified in the themes that emerged from this review. This inherent variation creates challenges in studying this area, both within local and across international boundaries. As there is increasing emphasis on interprofessional education, defining nursing education models and having an agreed taxonomy is important. The countries represented and the scope of inquiry is testament to worldwide interest in identifying effective approaches within clinical education and evaluating the impact of innovations. This review found that regardless of the model of clinical education or type of supervision there are themes which transcend the 'models' and contextual constraints. These were the centrality of professional relationships, need for consistency and continuity in clinical education delivery, the opportunity for varied clinical education/supervision models and ensuring the viability of the model to function as designed. These themes indicate that differing models can have favourable attributes that are able to promote learning in the clinical setting. In addition, these themes inform the effective implementation of existing models and design of novel models in the future.

The importance of relationships has been found in other studies, for example the pivotal role of the supervisory relationship for student satisfaction (Courtney-Pratt et al. 2012; Warne et al. 2010). Positive relationships promote student engagement, generate sufficient challenge for learning to occur and support constructive feedback (Grealish & Ranse 2009). The notion of relationship extends to students having sufficient time to develop therapeutic interactions and shift from seeing a *patient and diagnosis*, through to understanding the *person* (James & Chapman 2009). Several studies reviewed consider longer placements that provide time for relationships to build, and create opportunities for students to integrate and contribute to the team result in greater satisfaction (Walker et al. 2013; Warne et al. 2010). Further, longer placements allow the student-supervisor relationship to develop sufficiently to offer an insightful and robust student assessment (Roxburgh 2014).

Whilst the student voice is dominant, the review has implications for those charged with the design and governance of clinical education. There is scope for different models and approaches dependant on the clinical setting, individual needs of students, and requirements over the program of study and to facilitate students' experiences of nursing within the broader health care context. In Chesser-Smyth's (2005) study, first year students equated learning nursing with 'doing' and skill acquisition,

which this review found was supported by a traditional model. Whereas, models such as preceptorship (Henderson, Twentyman & Heel 2006) or student wards (Hellström-Hyson, Mårtensson & Kristofferzon 2012) promoted independence, offering options to address the concern that final year students may lack preparation for the real world workplace (Allan et al., 2011). Roxburgh (2014b) found students have insight into the evolution of their needs across time and what different models offer. Utilising a variety of models may support increased diversification and offer less traditional settings such as community or primary health, as ways to support students (Smith, Spadoni & Proper 2013).

The success of any particular nursing clinical education model depends on its reliability, validity, viability and sustainability. Better understanding the elements in models that drive success, such as adequately prepared supervisors or placement duration, is likely to be critical to optimising clinical learning outcomes. There is value in exploring models of clinical education as a whole, but scope to examine specific components and identify what is effective and why, across models. This review focused on student perceptions which may be less sensitive to the logistics of implementation or viability, hence the views of clinical staff, academics and professional staff would further inform future research.

2.8: Limitations in this review

This review was restricted by specifically seeking studies evaluating more than one model of clinical education/supervision. Limiting the review to papers published in the English language, excluded insights from papers in other languages. The diversity in methods, and range of what, where and whom was studied in included papers, meant the data could not be aggregated or synthesised in a standard form. However, the four emergent themes have a level of generalisability within these local contextual constraints. Although the review was conducted in accordance with the PRISMA statement and the heterogeneity prevented a meta-analysis from being undertaken.

Finally, the review selectively looked at students' perceptions and experiences and other stakeholder's views are not represented. The views of staff, supervisors or mentors may yield contrasting views, worthy of further exploration.

2.9: Summary

The findings of this integrative review did not identify a distinct, single optimal model for undergraduate nurse clinical education. Rather the emergent themes suggested that a variety of approaches may best address the needs of students and accommodate the wide diversity of clinical settings within which nurse education can, and will increasingly, occur. Whatever approach or model is taken to clinical education and/or the supervision of students the need for consistency, continuity and ensuring the viability of the model were factors for successful implementation. In addition, as borne out by many studies, the centrality of nurturing relationships was strongly evident in the findings of this review (Papastavrou et al. 2010; Saarikoski et al. 2002; Saarikoski et al. 2008; Sandvik et al. 2015; Courtney-Pratt et al. 2011 & Myall, Levett-Jones & Lathlean 2008).

Hence, the identification of points of consensus across differing models of clinical education may be a valuable mechanism in illuminating future direction. In addition, the central tenet of clinical education brings together the student, supervisor and learning opportunities. In turn this is influenced by the workplace as a learning environment, by the individual student as autonomous learner and by the curriculum design.

2.10: Engagement with the literature

A system of automatic data base searches and email alerts were established via the databases sourced in this literature review, to enable continued engagement with the literature. In addition, the literature review was repeated in accordance with the search methods given on page 19 on 2nd December 2017. The same process to screen, evaluate and eliminate papers was followed. The revised search for 2016-2017 identified four papers which from the student perspective compared or contrasted clinical education models or models of student supervision. Papers identified by these processes informed and contributed to the discussion chapter (Chapter Seven).

2.11: Chapter summary

The literature reviewed in this chapter highlights some of the challenges in researching across contextual boundaries at either a local or international level, when highly variable approaches to clinical education and supervision models exist. This contextual diversity creates a raft of variables which influence exploration of the issues. Quantitative studies using established validated tools including CLEI and CLES have repeatedly endorsed the role of relationships between student and

supervisor and student centred approach. However, by their nature these tools can be limited in examining the wider dimensions and layers of influence at across healthcare and education systems. In addition to empirical research, clinical education is informed by the grey literature records, as key contextual parameters, for example, the required number of clinical experience hours, can be a directive of a governing body's guidelines rather than an evidence-based phenomena. In addition, several high profile reports offer further guidance for those charged with clinical curricula re-design, including the Willis Commission report (Willis 2012) and the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013).

The literature in this chapter relates to differing clinical settings yet the acute care setting is most represented. As healthcare is considered to be amidst a wave of reform to address the needs of an aging population and growing prevalence of chronic disease, incorporating research into primary or community care settings, for example, as hosts for clinical learning is also necessary.

The findings from this literature review and the issues raised in Chapter One suggest novel approaches are required to identifying what meaningful clinical experiences *look like* when the systems work well, at the micro level but also considering the influences at a macro level. In addition, inviting research participants to project their vision of the future is warranted, as those experiencing or involved with clinical education in the here and now, may be some of the best placed to see it forward.

The following chapter, details the research design that addressed the aims and objectives of this study.

CHAPTER THREE: FRAMEWORKS, RESEARCH DESIGN AND METHODS

'For time and the world do not stand still. Change is the law of life. And those who look only to the past or the present are certain to miss the future'

John F. Kennedy[9]

3.1: Introduction

The opening chapters of this thesis have established the background and basis for the doctoral study. The introductory chapter considered the drivers, past, present and future challenging undergraduate clinical learning experiences. As these challenges are numerous, and significant expansion and diversification of healthcare is predicted, this is a vital time for invigorated thinking into the clinical component of nurse education. The literature review in Chapter Two demonstrated that a range of contextual influences result in diverse models of clinical education and student supervision. Whilst consensus for an optimal model of undergraduate clinical education was not evident, shared values and strategies emerged as key predictors of positive student experiences along with evidence of common challenges and constraints. This current study, therefore, sought an innovative way to compare divergent models of clinical education and add to what is already known about the creation of meaningful, positive clinical learning experiences to inform best practice. From this foundation the current research study was conceptualised and this chapter details the frameworks, research design and methods utilised to address the research aims.

This study has captured personal narratives about individual perceptions and understanding of meaningful clinical experiences and therefore adopted a qualitative approach. However, as the clinical components of undergraduate programs are quantified in terms of length and duration, a quantitative element was incorporated to specifically explore this aspect of clinical education. Given that several data collection methods and data sources were considered, case study methodology emerged as a means to study different systems of preparatory nurse education in a real world context (Donnelly & Wiechula 2012). To promote a solutions focused stance the principles of appreciative inquiry, a strengths-based approach to research guided the research process. In

[9] Address in the Assembly Hall at the Paulskirche in Frankfurt. June 25, 1963 John F Kennedy, XXXV President of the United States, 1961-1963. The American Presidency Project. Accessed: http://www.presidency.ucsb.edu/ws/?pid=9303

summary, this is a two-site, cross national study using an embedded case study design, informed by an appreciative inquiry framework.

The design is explored in the following chapter including a description of the study sites, the sampling and selection of participants and approaches taken to data collection and analysis. Also included is a discussion of the relational and ethical considerations and challenges encountered, particularly with student recruitment.

3.2: Theoretical perspective and methodological considerations

3.2.1: The Paradigm of Inquiry

The practice-based, clinical component of nursing programs immerses the student into unique social and contextualised environments. Each episode of clinical learning is a distinct and multi-layered interaction between the student, staff and patients, giving each student a highly individualised experience. Learning during clinical placement experiences and the creation of individual knowledge, can be conceptualised as occurring via a process of 'transformation of experience' (Kolb 1984, p.38). As explained by Lisko and O'Dell (2010) this transformation involves the integration of new experiences into an individual's pre-existing cognitive frameworks, incrementally changing the way an individual thinks and behaves. The creation of new personal knowledge for nursing students is therefore an individual, nonlinear, continuous and ongoing process, resulting in what Ford-Gilboe, Campbell and Berman (1995) describe as multiple realties that are holistic, local and specific.

Each individual student's educational and professional transformation occurs within the wider socio-political context of both the higher education framework and the healthcare system which, as outlined in Chapter One, are constantly evolving. Although student nurses are transient guests in the health care setting whilst on clinical placement, they are active participants within the changing and evolving knowledge-rich world of healthcare. Nursing students engage in social interactions which shape their own placement experiences with people, practices, relationships, emotions and feelings in a sociocultural approach to co-constructing knowledge (John-Steiner & Mahn 1996), shaping the nurse the student becomes. As such, students have an insightful platform from which to contribute to research into the clinical learning experience and how to enhance this experience to better serve future need.

The context within which students engage in clinical based education depends on the design of the 'practice curricula' (Billett 2014). Pivotal to this practice curricula are the academic and professional staff within the education institution who design and implement curricula to meet educational objectives within local context and constraint. The individual and collective knowledge from exposure to the healthcare and/or higher/tertiary education sectors ensures that academic and professional staff have unique experiences and personal ontological views on the provision of clinical experiences. Consequently, staff engaged in nurse education and current students have a range of perspectives, which translate into a wealth of realities shaped by each individual via their interface with the wider complex social milieu of healthcare and education.

The need to explore and understand the knowledge, as constructed by the people invested in student placement learning, pointed to an overarching qualitative design and an epistemological stance of constructivism. The desire to explore the varied perceptions of clinical education required a design that would capture the breadth and diversity of experience across typical and more obscure clinical settings. The qualitative paradigm seeks to 'illuminate human experience' (Ayres et al. 2003, p.871), which is an appropriate lens for the main aims and research objectives of this study (Chapter One, p.12).

Constructivist epistemology embraces the contextual and individual influences that contribute to a meaningful learning experience (Peters 2000, Adams 2006). Constructivism replaces the notion of truth with that of reality, and according to Peters (2000 p. 167) in constructivist theory 'one has to experience the world' to know and understand it, making learning and knowledge development active processes. Constructivism takes differing forms and Vygotsky's (1962) social constructivism emphasises social interaction as significant in the process of developing knowledge and understanding. A constructivism epistemology, unlike traditional pedagogy, considers the students' prior experience as foundational and able to be built upon (Peters 2000). Increasingly nursing attracts students from a range of backgrounds, including mature students with a wealth of pre-existing knowledge and skills and the premise of Benner's (1984) landmark 'Novice to Expert' demonstrates the individuals' need to build and transform knowledge from their own world view.

In this current study, taking a broad-brush approach with an inductive stance would invite rich descriptions and understandings of clinical learning experiences from participants, as well as encouraging creative thinking about possible innovations. Consequently, a qualitative approach dominates the study design and data collection methods. Embedded in this qualitative approach,

were several targeted questions to generate quantifiable data in relation to the measurable aspects of the clinical placement. This includes parameters typically defined and expressed as the number of weeks, shifts or hours students undertake. The quantitative component specifically aimed to address study objective 2.

Professional experience and examination of the literature indicates that the provision of clinical placements is complex and challenging, with significant energy and resources associated with clinical placement provision. In addition, large student cohorts in many higher education organisations risk de-personalising the learning experience. In an Australian study, Ralph et al. (2017) noted that constraints, including, satisfying minimum standards and meeting budgets can result in those charged with curriculum design in nursing 'settling for less' (Ralph et al. 2017, p.119). There is a risk of the need to secure sufficient placements, hence *quantity,* becoming more of a driver than the perceived *quality* of experience.

However, students do report that rich, meaningful, even transformational learning experiences do occur on clinical placements. These are occasions when *it* all comes together and the purpose of this study was to capture and understand what contributed to the meaningful, rewarding or awesome experiences and what factors came together when this happens. Consequently two main components drove the design: case study and appreciative inquiry.

3.2.2: Researching appreciatively

The position taken in this research was a 'paradigm' shift to an 'affirmative, relational, boundary expanding and imaginative' approach as advocated by Carter (2006a, p.187). The shift to a solutions focused way of working guided by appreciative inquiry (Carter 2006a, Enright et al. 2014), allowed the researcher to highlight the best of the past and present to inform the future direction for clinical education. Appreciative inquiry also provided a platform to examine shared values and strengths across models of education, stakeholders and countries, and a novel means for researching this field.

Appreciative inquiry originated as a guide to organisational change, focusing on the positive, seeking out the best or what works to generate creative thinking and proactive solutions rather than focusing on problems (Clarke & Thornton 2014; Scerri et al. 2015 & Trajkovski et al. 2013). Increasingly utilised as a research framework, the notion of a strengths base as a 'good philosophical starting point' for the study (Carter 2006b, p.49), was particularly pertinent in the challenge-laden

world of clinical placement provision, where negative foci can predominate. According to Enright et al. (2014), appreciative inquiry should be considered an overriding philosophy rather than a precise, specified set of research techniques or method and appreciative inquiry offers an inventive means to openly explore a research area.

Applied to this research study, the intention was capture the *best of what is* within preparatory nurse clinical education (Coghlan et al. 2003) and to envision *what could be*, to determine potential areas for transformation and change. Using appreciative inquiry as a guide was also a constructive mechanism to invite participants to examine their experiences of clinical education and to actively generate positive imagery, language and creative thinking for future innovation. In their project to promote inclusivity in an education institution, Kadi-Hanifi et al. (2014, p.585) described this as the 'liberating' effect of appreciative inquiry as dialogue proceeds unhampered by policy, institutional agendas or conventions.

Appreciative inquiry aimed to challenge participants to view the clinical placement, typically measured by time and place, in novel ways (Stowell 2013). Using appreciative inquiry encourages exploration of how the context and social interaction can generate an understanding of new realities and contribute to advancement (Richer et al. 2009); in this study, the exploration of placements. Richer et al. (2009) propose that appreciative inquiry can challenge unquestioned beliefs and assumptions; this is timely in light of current quest for reform. Considering the past, present and future as a continuum, Hammond (1998) suggests that using appreciative inquiry allows people to retain parts of the past which makes them more comfortable, however, what is carried forward should be the best of the past.

In this study, the philosophy, principles and processes underpinning appreciative inquiry particularly guided the design and development of data collection methods. Originally proposed by Cooperrider and Srivastva (1987), at the core of the appreciative inquiry process is the selection of an 'affirmative topic' (Cooperrider & Whitney 2001). In this study the affirmative topic choice and central tenet were positive perceptions and experiences within the provision of undergraduate nurse clinical learning experiences. As Cooperrider, Whitney and Stavros (2003) state, considered and informed topic areas define the scope of the research inquiry and provide a framework for the subsequent design of data collection tools within the phases of appreciative inquiry.

3.2.3: Phases of Appreciative Inquiry

With an affirmative topic as a focus, the application of the full appreciative inquiry process has four phases: *Discover, Dream, Design and Deliver*, and the principles of appreciative inquiry, discussed later, underpin each phase (Cooperrider & Srivastra 1987). The appreciative inquiry 4-D cycle is represented diagrammatically in Figure 3.1 and the four phases identify:

- 'the best of what is' (Discover), followed by exploration of
- 'what might be' (Dream), which develops into
- 'what could be' (Design) and finally
- 'what can be' (Deliver).

Figure 3.1: The 4-D cycle of appreciative inquiry (Cooperrider, Whitney & Stavros 2003, p.5)

The approach in the current study was informed by the appreciative inquiry process and principles, to generate a strengths based dialogue to inform understanding and recommendations. Appreciative inquiry was conceptualised into the design and data collection as follows, with emphasis on the discovery and dream phases:

- Discovery – this phase values the *best of what is,* to discover what has been done well in the past and is working well in the present (Ludema, Cooperrider & Barrett 2001). In this study, positively framed questions promoted story telling about experiences and values encouraging participants to consider strengths and achievements in their experience of clinical education. This phase aims to establish what things *looked like* when everything worked well (Trajkovski et al. 2013).
- Dream – this phase invites participants to dream about *what could be* and design a better future (Ludema, Cooperrider & Barrett 2001). Participants were asked to visualise or describe what it would be like if they could change, enhance or develop any aspect of clinical education, so *the best* occurred all the time (Carter 2006; Trajkovski et al. 2013).
- Design – this phase aligns with the analysis of the findings to identify the *best of what is* and *what could be,* to move towards a collective thinking on an envisioned future for clinical education (Trajkovski et al. 2013).
- Delivery - in this study this phase takes the form of recommendations for design and best practice in the provision of clinical education experiences and the dissemination of the findings of the study.

Each of the phases in the appreciative inquiry process is informed by the five principles of appreciative inquiry, as summarised by Bushe (2013):

1) The **constructionist principle:** what people believe is true determines what they do and relationships are central to how we think and act. In organisations, people co-construct their world through dialogue and interaction. Deliberate inquiry stimulates new ways of looking at the everyday to create new ideas for development.

2) The **principle of simultaneity** proposes that the very nature of inquiry changes the systems you are inquiring about acting as a catalyst for dialogue, learning and exploration. Questions are inevitably directional and the frequently asked questions or those eagerly discussed will drive social systems.

3) The **poetic principle** proposes that the story of an organisation exists in the everyday narratives of the people in the organisation and is constantly evolving. Consequently, how questions are worded in an inquiry has a major impact, triggering particular experiences or understanding. Hence, maintaining a positive focus is important at all phases of the inquiry.

4) The **anticipatory principle** proposes that human systems are constantly evolving and the future we want is a powerful driver. Appreciative inquiry promotes 'artful creation of positive imagery' (Cooperrider & Whitney 2001, p.17) in groups of people to envisage the future.

5) The **positive principle** proposes that social cohesion and positivity are required in order to sustain change. The promotion of relationships amongst people supports shared engagement in inquiry and a positive environment generates new ideas and innovation.

These appreciative inquiry principles guided the development of data collection tools and the analysis of the findings, as will be described in later sections of this chapter.

3.2.4: Strengths and limitations of appreciative inquiry

The adoption of appreciative inquiry and a shift from a problem based research paradigm to one of positive inquiry is a deliberate research strategy. However, researchers using appreciative inquiry have been accused of 'wearing rose coloured glasses' in their research endeavours (Carter 2006b, p.52). Carter (2006b) acknowledges that appreciative inquiry oriented research prioritises the positive, and questions if this is any different to actively seeking out problems for study, as the rigor within the study determines the robustness, credibility and authenticity of the research. A further challenge for the appreciative researcher, as noted by Carter, Cummings and Cooper (2007) and Trajkovski et al. (2013) is the necessity to generate a consistent positive focus, when participants may drift to negative issues. Hence, materials developed for this study explained the appreciative approach and made this explicit, for example, in participant invitations and information sheets. In addition, explanations and the opportunity for clarification were provide, for example, at the commencement of interviews.

The methodological flexibility afforded by appreciative inquiry has been considered a limitation and strength (Enright et al. 2014, Trajkovski et al. 2013). Dematteo and Reeves (2011) found many of their study participants perceived the 'positiveness' of researching appreciatively, refreshing in contrast to the traditional 'problem-based' approach evident in healthcare research. This was the desired effect sought in this current study as the positive philosophy was used to deliberately guide the direction of the dialogue in an affirmative direction and hence was viewed as a strength. Hence, participants were encouraged to engage with the study as a means to inform positive change.

3.3: Case study methodology

3.3.1: Study design – development and decision making

In conceptualising this study, I wanted to capitalise on my own experience and understanding of two nurse education programs. This understanding was the basis for the development of a two site, cross national study using an embedded case study design. Each of the two *cases* is a preparatory nurse education program, with differing models of clinical education.

Case Study Methodology

Case study originating in the social sciences, has been used in many situations and disciplines (Yin 2014). Anthony and Jack's (2009) integrative review found case study use in nursing research increasing, valued for its capacity to describe, explore, understand and evaluate real life situations. Case study is also frequently used in education-based research (Yazan 2015). As a methodology, case study is both process and product (Luck, Jackson & Usher 2006; Stake 1995) and offers methodological flexibility, attributed to its paradigmatic independence, neither wholly associated with quantitative or qualitative philosophy (Jones & Lyons 2004; Luck, Jackson & Usher 2006).

The methodological flexibility is explored in Yazan's (2015) detailed analysis of three widely cited 'traditions' for case study, those of Merriam (1998), Stake (1995) and Yin (2002). Each methodologist has their own conceptualisation of case study, from design through to dissemination of the findings, and are considered to be the foundational methodologies in case study research. Yazan (2015) considers the epistemological stance of both Merriam and Stake is one of constructivism such that 'reality is constructed by individuals interacting with their social worlds' (Merriam, 1998, p.6). The researcher gathers and interprets those realities to generate new knowledge of the phenomena being studied (Stake 1995). In contrast, Yin is considered not to distinguish between qualitative and quantitative case study and is supportive of mixing qualitative and quantitative data collection methods (Yazan 2015; Yin 2014). As this study is primarily qualitative, the case study methodology of Merriam (1998) and Stake (1995) inform the design and analysis.

Acknowledging the complexity in defining case study, Luck, Jackson and Usher (2006, p.104) propose that case study is a *'detailed, intensive study of a particular contextual, and bounded phenomena that is undertaken in real life situations'.* This is an apt definition for this current study into a real life, social phenomena and case study supports the questions being asked, the descriptive questions, *what works well* and the explanatory questions, *why or how* (Yin 2014). A bounded

phenomena according to Merriam (1998) can be an organisation, program, a process, a person or social entity and is distinct from a case report such as of a single scientific or medical case (Hyett, Kenny & Dickson-Swift 2014).

Two or more cases in a study, Yin (2014) describes as a multiple case study which can be 'holistic' or 'embedded'. Holistic case studies have a single unit of analysis – 'the case' itself, whereas embedded case studies have more than one unit of analysis. Essentially, these are subunits of data, permitting diverse data collection techniques and multiple data sources which contribute to the overall analysis (Scholz & Tietje, 2002; Yin 2014). Merriam (1998) and Stake (1995) advocate for the incorporation of multiple sources of evidence in the design so that data can come together via triangulation. Individuals, units or teams, documents and whole organisations are seen by Yin (2014) as potential units of analysis. In addition, by incorporating what Yin (1993) describes as embedded units in the design, the researcher is able to address specific subunits of information.

The value of two or more cases, Yin (2014) asserts, is the analytical benefit. Multiple cases may offer contrasting experiences of the same phenomena or may allow for common themes to emerge. The design for this study was a two site, embedded case study, largely exploratory in epistemological status with some explanatory elements. The choice of more than one case, allows the researcher to make 'comparison and contrast between the cases as well as a deep and rich look at each case' (Meyer 2001, p.333). However, the use of more than one case does not necessarily support generalisability any more than working with one case or the representativeness sought by quantitative sampling (Meyer 2001).

Donnelly and Wiechula (2012) argue that clinical education is a challenging area to investigate using traditional qualitative or quantitative research methodologies, and is well suited to the methodological flexibility case study affords. This may, in part, relate to a lack of defined variables as the boundaries between the studied phenomenon and the context are not, as in this study, always clearly evident (Yin 1994). McAndrew and Warne (2005) add that the interaction between various voices and perspectives within a case and the ability to give voice to the unheard are further assets of case study methodology and relevant to this present study.

As Luck, Jackson and Usher (2006) and Hyett et al. (2014) observe, the researcher must be clear in their consideration of the *case* and what the case is a *case of*. Miles and Huberman (1994) define a case as 'a phenomenon of some sort occurring in a bounded context'. When using case study as a methodological approach, Yin (2014, p.33) also refers to the importance of defining or 'bounding

the case'. Setting boundaries for the case contains the phenomena under study and determines what it is not a case off (Baxter & Jack 2008). Examples include, a case being bounded by time and place (Ragin & Becker 1992) or an activity or event (Creswell 1994). In this study the cases, were *cases of* two differing undergraduate nurse education programs with variation in structure and contextual factors, thus representing contrasting cases. In particular the phenomena under study were the structure, features and implementation of the clinical curricula that contribute to meaningful clinical learning experiences and how such experiences can be enhanced in the future.

Stake (2000) also emphasises the value in contextualising each 'case' to highlight the unique elements as well as any similarities. In addition, various contexts and influences, be they economic, political or societal, may also feature as part of each case (Hyett, Kenny & Dickson-Swift 2014). Within healthcare and nursing in general there are commonalities between the structures and processes in Australia and the UK. However, over time, nurse education systems have evolved with some differences evident in facets of the curricula, supervision models and placement duration.

Luck, Jackson and Usher (2006) suggest that the 'case of' may be pre-determined and the researcher identifies variables of interest prior to undertaking the case study. Alternatively, the case is interpreted inductively as it progresses. In this study, seeking to discover what works well in the provision of nurse clinical education and *what could be*, created a level of pre-determined direction for data collection. However, the open ended questioning adopted in the study, guided by appreciative inquiry, required flexibility when interpreting the case throughout the research process. Hence, elements of both approaches were utilised and facilitated the identification of shared meaning and understanding, as well as points of difference, both within each case, and between the two cases.

3.3.2: Case study selection - Sites

This section presents an overview of the two cases, providing a platform from which to appreciate the research findings in subsequent chapters.

In this study, the cases are bounded as Site 1 and Site 2 (the place) with their respective nurse education programs (Site 1 BN program and Site 2 BSc in Nursing) and the model of clinical education within that program (the activity). The two sites were selected because of their differences and the researcher's experience of both the UK's and Australian systems of nurse education. Both sites offer a three-year tertiary program as the requisite preparation for registration as a nurse, though Site 1

also offers an accelerated 2 year program. Some key differences such as the duration and structure of the clinical placements and the model of student supervision are indicative of the country or state level requirements. Further variables are given in Table 3.1 (p. 50).

The first case (Site 1) –was an undergraduate Bachelor of Nursing (BN) program at a higher education facility in New South Wales, Australia, and the second case (Site 2) was a pre-registration Bachelor of Science (BSc) Nursing program at an urban higher education facility in the north west of England, UK. Each program is well established with a representative cohort of students for their location and validated by the relevant National Governing body, the Nursing and Midwifery Council in the UK and the Nursing and Midwifery Board in Australia. Both programs were considered to be representative of the preparatory nursing programs in each country; however, it is acknowledged that the program requirements within each country allow for flexibility in the implementation of the curriculum.

The BSc Nursing degree in the UK and the BN degree in Australia confer eligibility for graduates to apply for registration as a nurse. Both programs of study are three academic years in duration but there are notable differences. In the UK students undertake a field specific program in adult, child, learning disability or mental health whereas in Australia there is a single registration. The student supervision model was based on the mentorship model at Site 2, whereas clinical facilitation was the dominant model at Site 1. Placement duration and the range of shifts students undertook also differed between the two sites. An outline of each program is presented in Table 3.1

3.4: Participants and recruitment

This section describes the research methods in relation to participant selection and recruitment.

3.4.1: Participants

There are numerous stakeholders in undergraduate clinical education, associated with the higher education sector and/or the healthcare care sector. In this study the focus was on stakeholders based in higher education and participants were drawn from final year students, academic and professional staff at both sites and clinical facilitators at Site 1.

Table 3.1: Summary of contextual features of preparatory nurse education at Site 1 and Site 2, in 2015.

FEATURE	Site 1: NSW, Australia	Site 2: England, UK
Registered Nurse Qualification	Bachelor of Nursing (BN)	Bachelor of Science Nursing (BSc)
Program duration (Standard)	3 years	3 years
Program type	Generic	Field – adult, child, mental health (learning disability not offered at Site 2)
Intakes	Once a year	Twice a year (adult and mental health). Once a year (child)
Estimated number of nursing students – all years (as of 2015)	1760	1310
Weeks per year 'on campus' contact time in the program	In 2015 - 2 x 14 week blocks (mix lectures, tutorials and clinical) plus exam weeks	Extended academic calendar.
Total number clinical hours	840	2300
Placement duration	1-4 weeks	8-12 weeks
Number of placements	10	6
Range of settings	One child, two mental health and a variety of aged or acute care focused placements, one elective	Placements are guided by the field of study: adult, child or mental health.
Student supervision	Majority Clinical Facilitation, some Facility Appointed Base Facilitation (FAB)	Mentorship, including sign-off mentor
Fees	An Australian Commonwealth supported student studying nursing full-time has a yearly fee contribution (as of 2015) between AUD $0–$6152. The Good Universities Guide (2017) indicates most universities charge the maximum. According to the official government site for international students, Study in Australia (2017), international students pay fees of $15,000 to $33,000, per annum for an undergraduate bachelor degree.	In England the means tested bursary for student nurses (covered fees and some living expenses), was phased out for new students on1st August 2017 (Ford 2017). It is replaced by the system of tuition fees and maintenance loans that students on non-health degrees apply for. For home students, Universities in England can charge up to a max. of £9,250 per year for undergraduate degree programs. International students, undergraduate fees for 2016/17 started at around £10,000 but can be higher.
Funding	The Clinical Training Funding Program via the Department of Health	Department of Health
Student financial support	HECS-HELP is a loan scheme to help eligible Commonwealth supported students to pay their student contribution to fees.	The learning support fund provides some funding for example, students with child dependants; cases of severe hardship or additional costs associated with placements.
Other	In NSW, clinical placements for most healthcare students in the public health system (NSW Health) are managed via a centralised web based system 'ClinConnect' hosted by the Health Education and Training Institute (HETI) (NSW Ministry of Health 2012).	In the UK students are primarily aligned to a NHS Trust(s) so clinical placements are guided by geographical location. Often a mix of Site 2 students across the years on placement at a given time.

The following inclusion and exclusion criteria were applied in the recruitment of participants:

Inclusion Criteria

- Student participants: undergraduate/pre-registration nursing students in their final year of study and at site 1 in any field, child, adult, or mental health.
- Staff participants: from any of the following groups: academic or professional staff, involved with any aspect of the organisation and delivery of the pre-registration/undergraduate nursing programs, employed on a permanent, contract or sessional basis.
- Staff participants must be willing to give written (or audio recorded) consent to participate in a semi-structured interview.
- Questionnaire participants (students or staff) must indicate consent before proceeding with the questionnaire.

Exclusion Criteria

- Refusal to provide informed consent.

3.4.2: Recruitment

Recruitment took place at Site 1 - Jan – August 2015 and at Site 2 – August – October 2015. All participation was voluntary.

Student Participants:

All final year nursing students were invited to participate in the study Site 1 2014 (n=450), 2015 (n= 534) and Site 2 2015 (n=332). As the study sought students' experiences of clinical learning experiences and their insights into *what could be,* final year student were considered to have the greatest range of experiences to draw from.

Table 3.2: Numbers of student participants at each site

Sample	Numbers (n=)	%
Site 1 2014	16 (450)	3.5%
Site 1 2015	38 (534)	7.1%
Site 2 2015	33 (332)	9.4%

Final year students were notified and invited to participate in an online 29 item questionnaire, via the student email systems and the University intranet systems. Invitations were forwarded by administrative or academic staff on the researcher's behalf in accordance with Human Research Ethics Committee (HREC) and access agreement requirements at each site. Two to three reminder emails and intranet announcements were sent. Following initial notification, face to face announcements were made in lectures or classes and poster-style advertisements displayed on notice boards. All modes of notification gave access to a Participant Information Sheet and a link to the online questionnaire. Participation was voluntary and anonymous and students were required to indicate their consent to access the survey.

Participant response rates with the online questionnaire were poor; thus prompting an examination of the possible contributory factors and solutions to the challenge of recruiting students at both sites. As a result, alternative paper copies of the questionnaire were made available on campus via lectures or classes for students to complete at their convenience. Coffee shop vouchers were additionally offered as a token reimbursement for the participants' time to participate in the study. Paper questionnaires were returned to an on-site drop-box to maintain the same anonymity afforded by the online questionnaire. The issues surrounding recruitment are further addressed in the Chapter Eight, within section on Methodological Issues and Challenges.

Copies of the email invitations, participant information sheet and promotional posters are included in Appendices 2, 3 and 4.

Staff Participants

Staff participants were invited from the following groups:

- Academic staff (including Divisional Leaders, Course and Module leaders and teaching staff) involved with the delivery of the pre-registration/undergraduate nursing programs, employed on a permanent, contract or sessional basis.
- Professional staff in student or clinical administrative units
- Clinical Facilitators (Site 1 only) - staff employed on a casual basis to provide direct supervision to students whilst on clinical placement.

The numbers of staff participants at each site is given in Table 3.3.

Table 3.3: Numbers of staff participants at each site.

	Academic Staff	Professional staff	Clinical Facilitators	Totals
Site 1	13	7	11	31
Site 2	15	2	N/A	17

For the staff interviews, recruitment continued until no new major themes were emergent. However, the use of appreciative inquiry, particularly the 'dream' question invites infinite views, and as stated by Wray, Markovic and Manderson (2007, p.1400), as each persons' experience is unique 'no data are ever truly saturated'. Hence, a level of pragmatism was employed in determining when the foremost issues had been captured in relation to the 'resources available and the depth of analysis desired' (Fugard & Potts 2015, p.670).

3.4.3: Data collection methods and tools

The qualitative data collection was designed to address the research aim and objectives and was centred on the following key questions:

- Which characteristics of undergraduate nurse clinical education models are conducive to promoting the quality and meaningfulness of the student experience and what individual and organisational factors support this?

- With reference to the clinically orientated components of the undergraduate nursing program (referred to as 'placements'), from the perspective of participants 'what works well', and how or why does 'it' work well?

- In what way does the practice based, clinical component of nurse education programs offer students something quintessential, a unique essence, within their education and preparation in becoming a nurse?

- How could nurse education be enhanced or changed to better meet the needs of students and what could preparatory nurse education look like in the future?

The selection of data collection methods was balanced between tools that would gather individual experiences and the pragmatic needs of collecting data at two sites. Staff were notified of the study and invited to participate via staff email and /or staff intranet announcements which were initiated by a research support staff member at each site. Staff were invited to participate in a semi-structured interview or nominal group technique focus group. All staff participants opted for interview with several staff at site 1 completing the interview in an

alternate online questionnaire format, whilst the researcher was conducting interviews in the UK. Copies of invitations, participant information sheets and consent forms are provided in Appendix 2, 3 and 5.

An online questionnaire was selected for students, due to the anticipated advantages of being of relatively cheap to administer, time efficient and able to reach diverse and large populations (Wright 2006). Within the student questionnaire there was an embedded quantitative element, designed to specifically address the research question:

- Is there a preferred structure and duration for each clinical placement and clinical education overall? What factors influence this?

Questionnaire

The questionnaire was self-administered, anonymous, with the online version hosted on a prominent commercially available secure platform. Subsequently, a paper-based version was utilised to promote participation. The questionnaire comprised 29 items, 10 demographic questions and 19 questions grouped around the following concepts:

- From the students' perspective, what contributed to their best or most valued clinical placement or clinical learning experience and why? (Discovery phase of appreciative inquiry).
- Students' ideas, suggestions and innovations that would enhance future clinical learning experiences or placements and what key positive changes would they make. (Dream phase of appreciative inquiry).
- The structure and duration of clinical placement and clinical component of the program overall.
- Demographic data was be collected including age, gender, local or international student, nature of any concurrent paid employment and average weekly hours of work during study and placement time.

As clinical placement duration is variable and ideal structure and duration is poorly understood, five items in the questionnaire asked questions about perceptions on the duration and structure of the clinical component. Though seemingly quantitative in nature, these questions were asked to specifically inform the qualitative data and discussion and were analysed in a descriptive, rather than statistical way.

Copies of the Australian and UK version of the questionnaires are included in Appendix 6

Semi-Structured Interviews

Given the exploratory nature of this study, a semi-structured interview format, aligned to the research questions, was used. King (1994) suggests in order to focus on the interviewee's world view, the interviewer needs to develop their interview outline with open questions. This generates a narrative approach which Carter, Cummings & Cooper (2007) and Michael (2005) propose, allows participants to tell their stories and captures their personal experiences. Interviews were conducted with staff following a schedule of four key questions:

- *What role and/or responsibilities do you have in regards to the provision of student clinical learning experiences/placements? Ascertained to orientate the researcher to the participant responses.*
- *In the overall approach to clinical education in this facility/institution, what do you feel are the positive features or strengths? Or in your experience or your role what works well in undergraduate nurse clinical education and why?* (Discovery phase of appreciative inquiry)
- *In your view/opinion, do clinical experiences serve a unique purpose in preparing learners for future practice?* (Discovery phase of appreciative inquiry)
- *If a miracle happened and you could have the 'best' undergraduate nurse clinical education all the time, what would or could this 'look' like'?* (Dream phase of appreciative inquiry)

A suite of other questions and prompts were developed to direct the conversation dependent on the participant's role or the factors raised. The full interview guide is included in Appendix 7.

Table 3.4: Summary of interview activity

	Individual interviews	Group Interviews	Online questionnaires
Site 1	18	2 x 3person , 1 x 2 person	5
Site 2	13	1 x 4 person	N/A

The majority of interviews were conducted face to face, and were conducted at a time and location convenient to the participant. All individual interviews were conducted in private offices or spaces. Telephone interviews were used for staff not based on campus at site 1 (n=3) who expressed a preference for telephone interview. Minor modifications to terminology were required and occasional clarification of local processes was required prior to conducting the UK interviews.

All the interviews were audio recorded with permission of participants and were transcribed verbatim by the researcher, however, to promote anonymity some speech traits and patterns or other identifying markers were omitted or coded. Mindful of the concerns raised by Forbat and Henderson (2005) that not all participants desire to see the spoken word transcribed into written form, transcripts were not returned to participants. The process of transcription provided an opportunity for complete immersion in the data. Rather than merely capturing the content - what was said, repeated engagement with the audio file enabled the refinement of the transcript and, as Davidson (2009) describes, brought focus to how things were said and the various points of emphasis.

3.5: Approaches to data analysis

Demographic and descriptive data was collected from student participants and summarised using descriptive statistics. A summary of the findings is presented within the Introduction to the Findings Chapters.

3.5.1: Qualitative data

Consistency and early engagement with the interview data was assured with the researcher transcribing all staff interviews, both from the UK and Australia. Each student participant's data entry, via the survey, was converted into a composite word document to act as a 'transcript' of their answers to all sections of the questionnaire. With qualitative methods, analysis begins shortly after data collection to support the clarification of issues and preliminary identification of themes. However, in this study, to allow for an open and 'narrative-rich communication' in line with appreciative inquiry (Cooperrider and Whitney 2001, p.74), initial analysis was limited to the streamlining of question development for the interviews. Thus, later interviewees were not limited or directed by questioning based on initial interviewee's responses. This retained the appreciative inquiry principles promoting wide and free expression, considered by Michael (2005) to being one of the benefits in adopting appreciative inquiry in data collection.

A thematic analysis, was informed by the process as described by Braun and Clarke (2006) and summarised in figure 3.2

Figure 3.2: Phases in thematic analysis adapted from (Braun and Clarke 2006, p.87)

Phases
• Familiarisation with the data – reading and re-reading, note making

- Generating initial codes – systematic coding across the data set, collating data relevant to each code
- Searching for themes – collating coded into initial themes
- Reviewing themes - testing themes to the coded extracts in each them and back again the entire data set
- Defining and naming themes – refinement of themes, establishing the story within the analysis
- Writing the overall analysis

At the conclusion of data collection there were 5 subsets of data:

- Site 1 staff interviews – quantitative data
- Site 2 staff interviews – quantitative data
- Site 1 Student qualitative data
- Site 2 Student qualitative data
- Site 1 and 2 Student quantitative data (combined), discussed later.

Following transcription of the interview data, rounds of reading, re-reading, listening and re-listening commenced the analysis to develop familiarity and immersion across the entire data set. Preliminary note making preceded the more formal derivation of 'codes'. All staff and student data was loaded into NVIVO 11 (QRS International 2015) as a means to support data coding, the development of themes and data management in general (Bazeley & Jacksoni 2013). Using NVIVO did not replace the need for myself as the researcher to drive the analysis and interpretation of the data however, it was a valuable platform within which to undertake this part of the research.

Each qualitative subset of data was coded independently of each other. Coding occurred in a largely inductive manner under three broad predetermined headings aligned to the research questions – what works well, what could be and the structure/duration of clinical. For each subset of data, initial broad coding was followed by rounds of refining and cleaning of the codes with each code bounded by a definition. Themes were abstracted from the coded text as described by (Attride-Stirling 2001). The text within each code was examined to draw out the patterns in the data and codes were condensed to determine an initial set of themes within NVIVO for each qualitative data set.

Descriptive and interpretive matrices (Miles, Huberman and Saldana 2014; Rosenberg and Yates 2007) were then utilised to provide a systematic way to visualise and compare and contrast the

themes across the subsets of data. The two sets of student data were mapped and compared in parallel to each other. The themes, with an occasional exception, were closely aligned for the two sites, supporting cross case contrasting and comparison. The themes were merged and further refined and re-defined as appropriate.

This process matching process was repeated with the two sets of staff data and the themes were confirmed.

3.5.2: Cross case analysis

As a final stage, the student and staff themes were mapped to each other with crossover of some themes identified between staff and student data. The rationale in undertaking this mapping was to achieve cross case analysis in order to 'deepen understanding and explanation' (Miles, Huberman and Saldana 2014, p.101). This resulted in seven themes and twenty three sub-themes. These were grouped following Attride Stirling's (2001) thematic structure into three overarching 'organising' themes, presented as Chapters Four, Five and Six.

In order to situate the findings presented in the Chapters Four, Five and Six, an adaptation of Bronfenbrenner's Ecological Systems Theory of Development (1977) is adopted in Chapter Seven: The Discussion. This conceptualisation of the findings, facilitates a means to explore the relationships within and across the themes and sub-themes at individual, organisational and wider professional levels, that emerged from the cross case analysis. An introduction to Bronfenbrenner's Ecological Systems Theory of Development is included in Chapter Seven as a gateway to the discussion.

3.5.3: Quantitative data within the student questionnaire

In the student questionnaire, quantitative data was sought on the following areas:

- Student preferences for placement structure – block versus continuous
- Student preferences for overall clinical time
- Preferred placement duration
- Type of shifts experienced
- Type and amount of paid employment

The quantitative data from the student questionnaire were collated using an excel spreadsheet. The data were summarised using descriptive statistics and presented in a series of tables to support corresponding qualitative data. No statistical testing was applied. These findings are included in Chapter Five.

3.6: Methodological challenges

3.6.1: The researcher, case interaction and ethical considerations

My experience as a clinician and academic in both the UK and Australia has contributed to the development of a professional understanding and personal opinion regarding undergraduate nurse education. Pre-existing knowledge of both the British and Australian healthcare and education systems affords insights into each approach; however, this also has potential to influence the research design and data analysis process. I fully acknowledge that I have my own beliefs and values about the very thing the research is about. I believe that nursing is both art and science and that the practice-based component of nursing education programs is an essential element in the preparation of the novice nurse. Having experience of both systems in this study meant there was a risk of comparing and contrasting my experiences rather than those of the participants.

Philosophically, my personal insights could be considered as either or both a strength or liability in relation to the undertaking of the research and its outcomes and hence these factors were addressed prior to data collection. The use of appreciative inquiry was a deliberate, overt mechanism to promote the pursuit of individual participant's perspectives and experiences. Appreciative inquiry positions the researcher as 'one expertise' (Carter 2006b, p.48) amongst others and this was particularly pertinent when interviewing colleagues and peers. The focus on the positive created a novel platform to engage in less threatening conversations both in the UK and Australia

3.6.2: Reflexivity

The adoption of processes for reflexivity was an important consideration and both personal and epistemological reflexivity were embraced early in the research process (Dowling 2006). According to Dowling (2006, p.8) reflexivity 'involves being aware in the moment of what is influencing the researcher's internal and external responses while simultaneously being aware of the researcher's relationship to the research topic and the participants'. Having worked in clinical education for many years, I was conscious of the need for personal reflexivity to appreciate how my own personal values and views could influence the collection and interpretation of the data (Jootun, McGee & Marland 2009). In contrast to reflection, Johnston, Pringle & Buchanan (2016, p.e1) consider reflexivity to be more actively applied at all stages of the research process as a means of 'continuing self-awareness' to promote rigour.

From an epistemological stance, the research design and research question further influence knowledge generation (Dowling 2006). Kinsella and Whiteford (2009, p.252) discuss epistemological reflexivity and how the continual questioning within reflexivity should promote the identification of 'positive possibility rather than an endless spiral of unproductive critique'. The use of appreciative inquiry as a guiding philosophy in this study, deliberately directed the inquiry, and reflexivity was integral in its adoption and application. Regular journaling, open supervision discussions and immersion as a full time student with the opportunity to take leave from my academic role were important, integral safeguards.

3.6.3: Insider and outsider status in research

In qualitative research, it is important for the researcher as the instrument of data collection to understand their position and its influence on the research (Blythe et al. 2013). In this study, my status as an employee at site 1, made me cognisant of my relationship to colleagues and potentially to final year students whom I may have encountered in an academic capacity. My experience placed me in the role of 'insider', particularly when interviewing staff. As an insider, advantages include access to participants, pre-existing knowledge and mutual understanding of the topic along with the ability to appreciate the subtleties and inferences in participant's responses (Blythe et al. 2012; Berger 2015). At study site 2, although I was not known to the participants identifying as a nurse, academic and researcher facilitated access across geographical and organisational boundaries. In addition, my knowledge of both the Australian and UK site's model of education promoted an equitable approach and flow to the interviews at both sites.

The limitations of being an insider include the need to maintain objectivity and not exploiting relationships (Blyth et al. 2012; Moore 2012). Several measures were taken to address being an insider including, temporarily stepping out of an academic role and the use of appreciative inquiry and open ended questioning to encourage participants to self-censor, direct the dialogue and champion the positives rather than being seen to criticise the system. Review of the initial interviews identified elements of interviewer 'familiarity', reinforcing participants' responses and facial expression that could be potentially problematic and these were addressed to achieve a neutral stance in subsequent interviews (McDermid et al. 2014). Consequently, as the researcher, I tried to function between insider and outsider, adapting to what Burns et al. (2012, p.59) refer to as a 'fluidity of in/out positionality'.

3.6.4: Attention to rigor

Along with the flexibility afforded by case study design is the need for strategies to ensure rigor within the conduct of the study and its ability to represent the participants' experiences. Key to this was the application of appreciative inquiry so that the breadth of subject matter would be captured. The combination of case study methodology and appreciative inquiry may appear somewhat eclectic; however, the aim of utilising such design was to yield rich results. This study was designed to liberate rather than constrain the participants' positive experiences of clinical education. The outcome of this study was not to produce statistically generalisable findings or representation (Barbour 2001), but to identify trigger points of similarity and difference in these two clinical education systems. The findings are presented as thick descriptions, incorporating quotes from participants, to allow the reader to determine the transferability of the findings to other contexts (Graneheim & Lundman 2004).

Credibility in qualitative research refers to the believability of the findings and connecting multiple perspectives within the study aimed to strengthen the credibility of the findings (Lincoln & Guba, 1985). Triangulation was exercised via the incorporation of a range of data sources and from academics, professional administration staff and students across two sites. The cyclic approach to the analysis generated a hierarchy of themes across the two cases rather than simply comparing sites or participant group. This facilitated the extraction of the prominent similarities and the differences across the data, bringing together the various sources of evidence to add depth and breadth to the data analysis and validity to the research findings (Becket 2012; Creswell 2007; Yin, 2003).

As case study methods allow for a range of data collection approaches, attention to methodological rigor must be applied within each activity (Anthony and Jack 2009; Yin 2014). Rigor was promoted in this study through systematic approaches to data collection, analysis, interpretation and synthesis guided closely by the researcher's supervision team, who all have extensive qualitative research experience, with two also particularly familiar with appreciative inquiry. Strategies to approach the analysis were discussed and tested prior to the commencement of formal coding and analysis and supervisory feedback was sought at each round of analysis. As all members of my supervisor team are higher education-based academics, this facilitated a form of member checking via the discussion on the interpretation of the findings. Establishing an audit trial allowed for the influences and actions of the researcher to be tracked and reviewed at any point in the research process (Koch 2006).

With only two cases represented in this study, it is acknowledged that transferability of the findings is limited, however the findings inform the broader area of undergraduate nurse clinical education (Kitto, Chesters & Grbich 2008).

3.6.5: Ethical and relational considerations

Guillemin and Gillam (2004) consider two facets in how the ethical considerations in research are addressed. They refer to obtaining the formalised ethics committee approval as 'procedural' ethics, whereas, 'ethics in practice', focuses on the day-to-day ethical issues in the undertaking of the research (Guillemin & Gillam 2004, p.263).

For the procedural ethics in this study, access permissions to invite staff and students to participate were secured from each study site in accordance with local procedure prior to seeking ethics approval. The initial application for ethical approval was sought via the Human Research Ethics Committee at the Australian institution and was granted. The ethics approval (HREC Approval Number 2014000652) and two subsequent approved amendments are included in Appendices 8 and 9. These approvals formed the basis of an application for ethics approval at Site 2 and ratification of the ethics approval of Site 1 was obtained (Approval number STEMH 378). The site 2 ethics approval is provided in Appendix 10.

Considerations throughout the undertaking of the research - the ethics in practice - were guided by the Beauchamp and Childress (2001) framework, and comprised the following the four principles:

- Respect for autonomy
- Justice
- Beneficence
- Non maleficence

Though beneficence and non-maleficence apply to all research, the principles of respect for autonomy and justice were particularly pertinent to this study.

Respect for autonomy

Central to the conduct of this research study was the respect for autonomy in promoting individuals making informed, non-coerced, autonomous decisions and choices (Beauchamp & Childress 2001). Informed consent requires full disclosure of the nature of the study including the right to refuse to participate, freedom to withdraw without reason and the potential risks

and anticipated benefits (Polit & Beck 2004). Consequently, participation was voluntary and all participants were initially invited to participate in the study via a third party, and replying directly to the researcher to protect anonymity. The participant information sheets were designed to be user friendly and adopted a question and answer format which Ahern (2012) advocates to make the risk and benefits of participation more accessible. The opportunity to clarify any aspect of the study and/or participation was offered prior to the commencement of all interviews and contact information provided at the commencement of the questionnaire. Participants consented to engage with the study in several ways. Participants in face-to-face interviews signed a consent form and in telephone interviews verbal consent was recorded at the start of the phone conversation. All online questionnaire access required the participant to acknowledge consent before proceeding.

Justice

In research, justice relates primarily to ensuing fair treatment and participants' right to privacy and confidentiality (Polit & Beck 2004). Orb, Eisenhauer & Wynaden (2001) consider justice to be based on the avoidance of exploitation and protecting vulnerable groups. Students could potentially be considered a vulnerable group and it was made explicit to students that participation or non-participation had no bearing on their grades or progress in the program.

Ensuring privacy is examined by Lewis (2003, p.68), who cautions on the complexities in anonymising data, in particularly the potential for 'indirect identification'. An illustration in this study was the need to de-identify speech traits or patterns and regional accents. In addition, in the findings chapters, quotes from staff are denoted with UK or Aus and 'HEI' (Higher Education Institution) as role titles could be key identifiers at each site.

Beneficence and non-maleficence

The principle of beneficence guides the researcher to balance the benefits of the research against the cost or risks involved. The longer term nature of beneficence was clarified to student participants, in that the findings in this study would not affect their program but their participation may benefit future students. It was perceived that staff saw the ongoing curriculum renewal cycle and scope for the findings in this study to contribute to future curricula.

The application of non-maleficence ensures that engagement with a research study should not harm those who participate. As clinical learning experiences can be stressful, particularly for students, whilst positive experiences were sought, distressing memories could evoke anxiety in students. Arrangements were therefore communicated at all stages of the study for students,

and for staff, as to where additional support could be accessed as required (Orb, Eisenhauer & Wynaden 2001).

Data Security

Finally, for data security, survey responses were stored online in a password protected account. Soft copies of these data were stored on a University secure site, and were login and password protected. Interview recordings and transcripts were stored on respective staff drive accounts at each study site with login and password protection. All transcripts are de-identified and all working versions of the data including paper copies of the transcripts, for example, for data analysis are de-identified including the remove of identifying comments, speech traits and patterns to protect participant identity. Any paper copies are kept in a located filing cabinet in a locked office, within a swipe card accessible, departmental area of the university.

3.7: Chapter summary

This chapter has detailed the frameworks, research design and methods informing the study design and data collection. Given the study's focus is a real life, phenomena, a predominantly qualitative approach was appropriate to generate and better understand staff and student experiences of clinical based learning. Given there are inherent differences in the two approaches to clinical education in the UK and Australia, case study provided an appropriate approach as it also supports the incorporation of multiple data collection methods and sources of data.

To generate a positive dialogue that looks to solutions rather than dwelling on the challenges within nurse clinical education, the strengths-based approach appreciative inquiry was employed as the driving philosophy in the research study. A small quantitative element was embedded in the study to examine perspectives on the amount of clinical time in the nursing programs and its influence, if any, to positive experiences.

The chapters that follow will present the findings from this research study. The opening section of Chapter Four will introduce the three findings chapters and the themes that emerged from the thematic analysis and cross case synthesis.

INTRODUCTION TO THE FINDINGS CHAPTERS FOUR, FIVE AND SIX

Within the shift of nurse education from the health sector to higher education sector in many countries, the clinical component of nursing programs has evolved less than its theoretical counterpart. A rotation of clinical placements continues to be the foundational model in many places and can, on the surface, appear little changed from the apprenticeship models of the past. However, whilst the approaches to clinical education at the sites in this study were underpinned by a rotational, block placement model, differences existed. These differences provided a platform from which to examine and contrast the *best of what is* in the provision of clinical education and *what could be*, in an ever changing healthcare, higher education and wider societal landscape.

The findings from this study indicated that the perceived disconnect arising when nurse education moved to the higher education sector has generated a complexity of roles, processes and procedures both established and emergent which enable clinical placements to 'work' as meaningful learning experiences. Many of these roles, processes and procedures aim to promote the connection or re-connection of 'health' and 'education' at multiple levels within the context of the range of historical, social and professional influences on the provision of clinical education. Connections were evident at the personal level (Chapter Four) bringing together the student, an experienced guide and learning opportunities within a given setting. In turn, this connected the student to nursing practice and ultimately, to the nurse they strive to become. At the organisational university-healthcare sector level (Chapter Five), the curriculum design or 'model' drives complex relationships aiming to support placement delivery. The final level of influence is at a broader contextual level, connecting to the nursing profession within a continuum of evolution and change (Chapter Six). Across all levels, the unique role clinical experiences are considered to have in preparatory nurse education is evident.

The findings highlight that no two clinical experiences are identical and no two students will have the same trajectory for their journey to becoming a nurse. Educational curricula are often conceptualised as a linear process and, indeed, learning objectives are mapped and planned incrementally across education programs. However, the clinical component in nursing is non-linear, generating an element of randomness. Despite this, there are occasions when everything 'comes together' and particularly meaningful experiences occur that can be transformational. The findings in this study contribute to understanding both the complexity of experience and the complex interconnected 'machinery' of the system that supports the provision of clinical placements and the experiences within. Across the findings chapters, creative solutions and

approaches to addressing the challenges within the business of clinical education provision were revealed.

Throughout the following chapters, the use of direct quotes from the participant narratives is adopted in order to allow participants' voices and expressions to illustrate the findings. Where necessary, patterns of language or expression that may identify participants have been removed to promote anonymity. Several acronyms feature in the quotes. These include Nurse Unit Manager (NUM), Clinical Nurse Consultant (CNC) and Practice Education Facilitator (PEF). Staff participants are identified as higher education institution staff (HEI) and students are represented by 'Std', with Aus denoting Site 1 (NSW, Australia) and UK denoting Site 2 (England, UK).

An outline of the structure adopted to organise and present the findings and themes in Chapters Four, Five and Six is given in Figure 4.0a and Figure 4.0b. In Figure 4.0b the organising themes, themes and sub-themes are integrated into a visual framework to depict the connecting concepts across the findings chapters. The sub-themes are organised and clustered around the concepts: becoming and being a nurse (orange), facilitated engagement with practice (green) and partnerships and future direction (blue). A summary of each findings chapter is presented below.

Chapter Four: The Clinical Placement: The student experience of learning in practice explores the students' experiences of clinical placement. Included in this chapter is a description of the people and processes that enable the student to engage in caring for patients and other associated healthcare activities in a real world setting. These aspects of the clinical experience have the potential to be changeable, fluid elements as every day is different. There are three themes in the chapter. The first theme describes how the placement unfolds from the students' first impressions, the staff-student encounter and the how students are connected with the opportunities each placement offers. The second theme considers the students' experience of nursing embedded in the real world of contextualised practice. The final theme examines how students identify with their learning in the clinical setting and how they reflect on their personal development and transition as a nurse. The student voice predominates in this chapter although some specific comments and observations made by staff are also incorporated. The demographic profile of the students is presented in Table 4.0.

Table 4.0: Student demographics

	NSW 2014	**NSW 2015**	**UK 2015**
Age range in years	21-46 (n=14)	20 -53 (n=35)	20-44 (n=28)
Mean age in years Overall 27.8yrs	30.3	27.3	27.1

Median age in years	28	24	26
Male	3	4	2
Female	11	31	26
International student	2	9	0
Local student	12	26	28
English is first language	11	22	26
English not first language	3	9	2
Healthcare experience prior to enrolment	EN/EEN 3, AIN, 1, Other 1. No/Nil 8	AIN 3, EN/EEN 3, Carer, 1 x RN no experience, No/Nil =23	HCA 4, Care/support work, Healthcare admin x1, No/Nil =18

Chapter Five: Clinical Education: The organisational dimension of clinical placements examines the complex bridging of healthcare and education and the structural and functional aspects of clinical curricula. Many of these features are set prior to the student commencing their program and are required to meet local and statutory regulations. This chapter combines student and staff perspectives on the implementation of the respective clinical education models and how healthcare and education organisations work collaboratively in the provision of clinical placements. Whilst the majority of findings presented are qualitative, selected quantitative elements from targeted questions related to factors, such as, placement duration are incorporated. This chapter is presented as two themes. The first looks at the design elements in the clinical component of the nursing program and factors that influence this design. The second theme presents the complex organisational aspects of clinical placements and maintenance of systems for student supervision.

Chapter Six: Nurse Education: Connecting with the past, creating the future, explored the diverse factors that drive or influence the current clinical education models and future considerations within nursing and healthcare. In this chapter, the narratives of staff, reflecting on past and present experiences, are most prominent. This chapter has two themes. The first explores continuum and evolution of nursing education and particularly the perceived disconnect that occurred between healthcare and education and its legacy. Local context and future solutions to make contemporary clinical education work effectively are also examined. The second theme considers being a nurse and the dynamic of nursing identity and its influence on the transition from student to beginning practitioner.

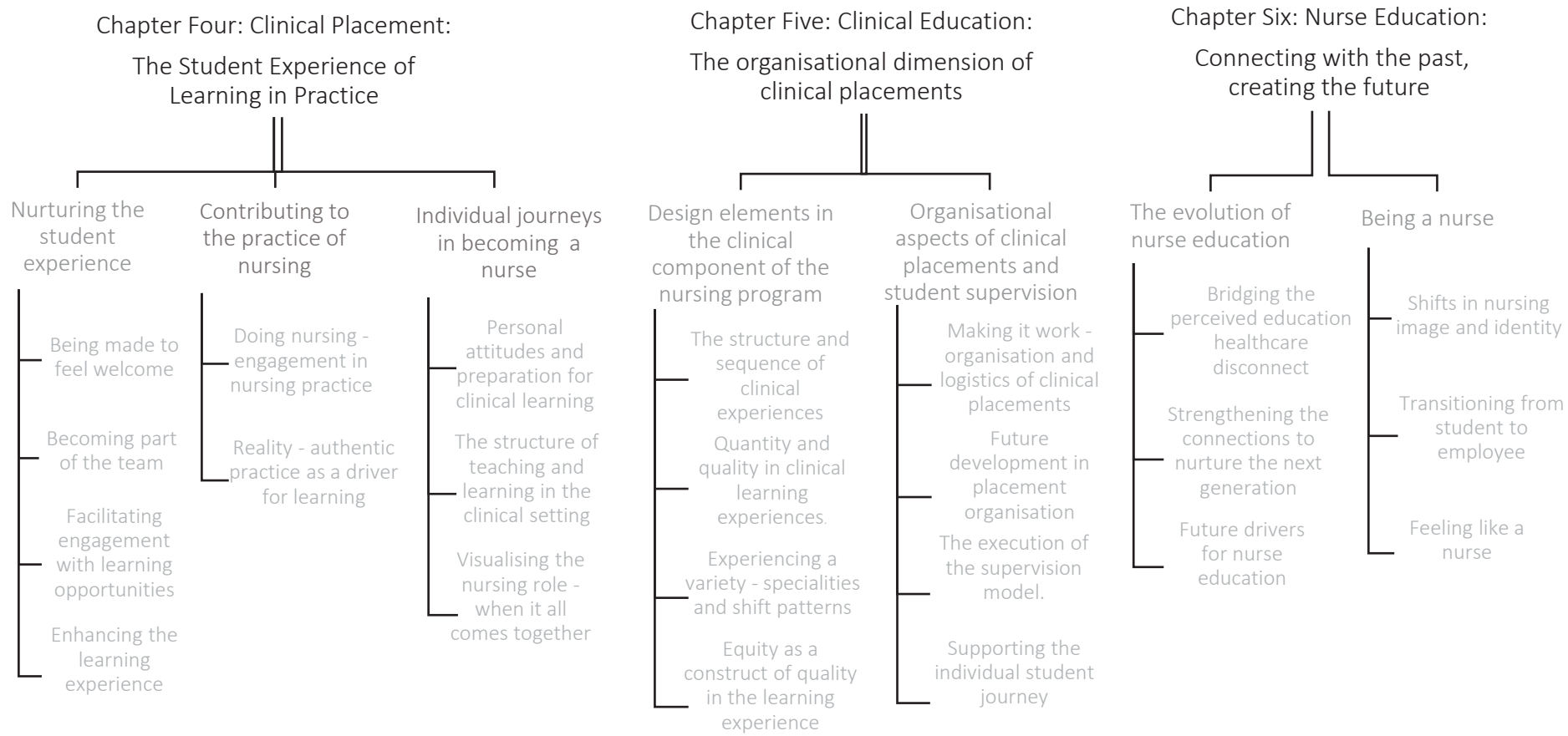


Figure 4.0a: Organising themes, themes and sub-themes in Chapters Four, Five and Six.

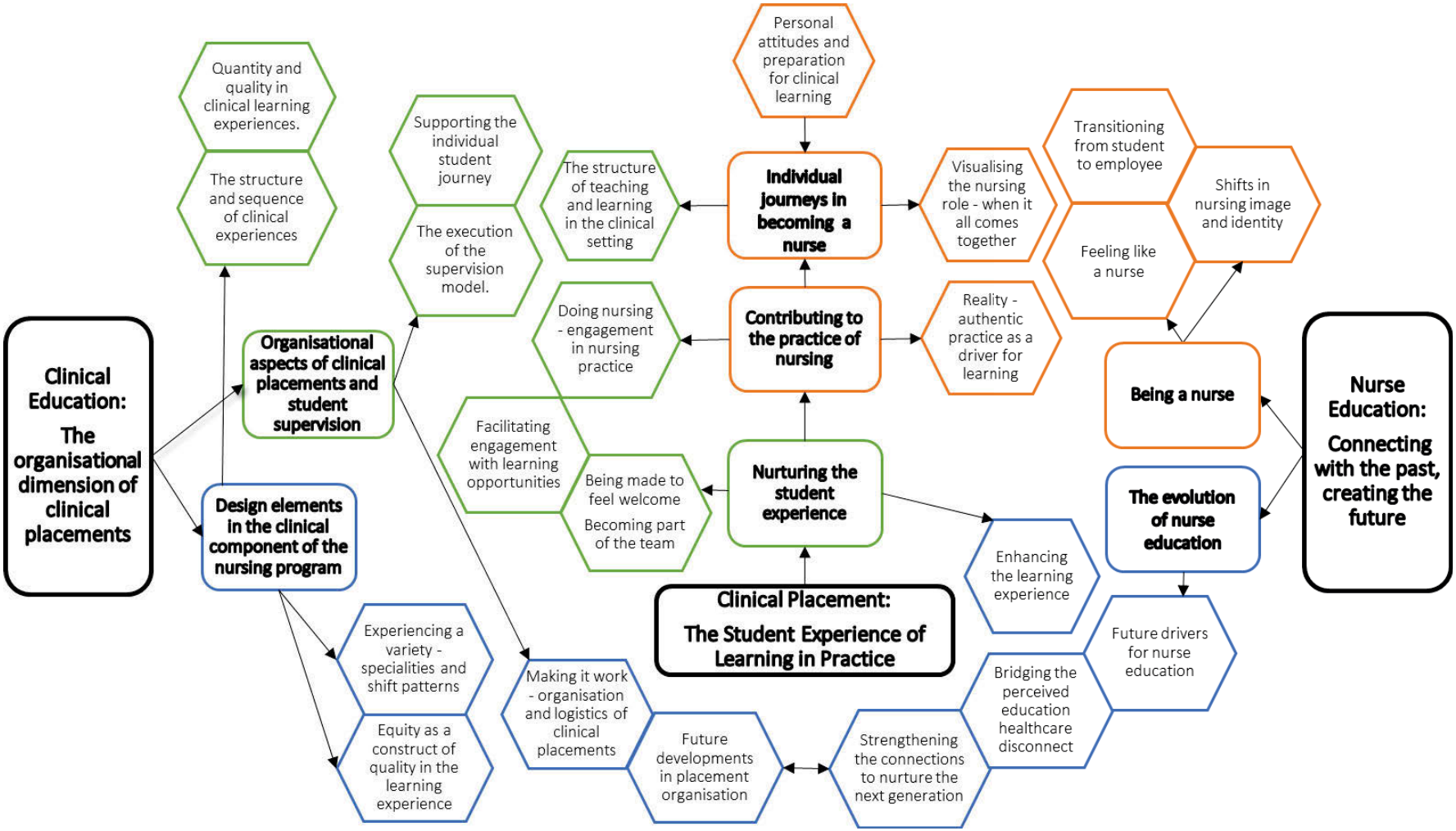


Figure 4.0b: Integrative framework of organising themes, themes and sub-themes.

CHAPTER FOUR: CLINICAL PLACEMENT – STUDENTS' EXPERIENCE OF LEARNING IN PRACTICE

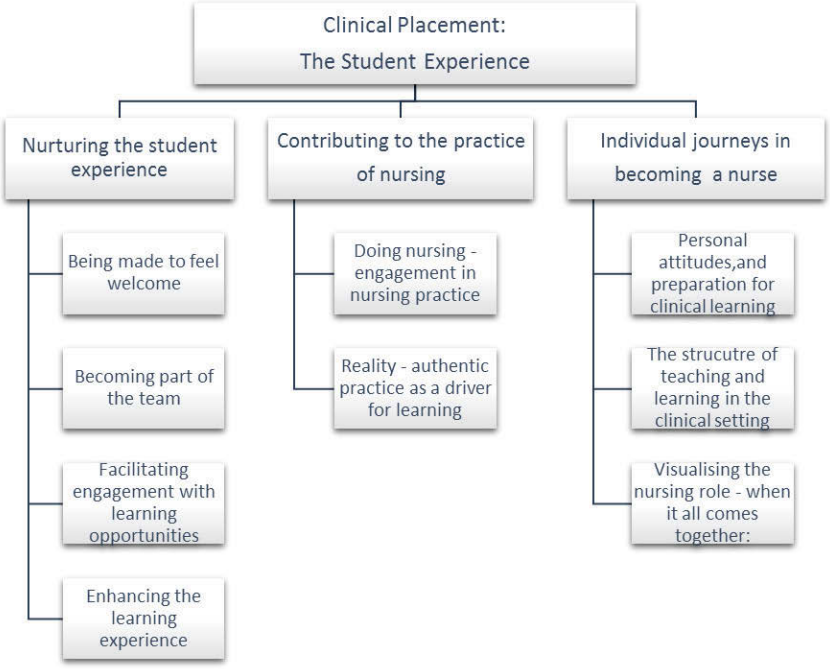
'Coming together is a beginning; keeping together is progress; working together is success.'

Henry Ford[10]

4.1: Introduction

For the duration of a clinical placement, each student is immersed in a unique and complex environment. The content and quality of the students' learning experiences are dependent on numerous variables within each clinical setting. These variables include patients, staff, local clinical and administrative practices and the student themselves. In this chapter, the individual student and their immediate experience of the clinical placement is the central focus. The thematic structure within the chapter is given in Figure 4.1.

Figure 4.1: Chapter Four: Overview of thematic structure.



In the first of three themes, the findings relate to how students and learning opportunities are brought together to discover the positive factors both in the people and processes that facilitate this connection. The second theme centres on students' engagement with authentic practice

[10] Attributed to Henry Ford, Founder of the Ford Motor Company, 1863 – 1947

and how they value their experience of 'doing' nursing. The third and final theme examines the students' transformation as they begin to identify and transition to be a nurse. The theme highlights how students approach their learning and their role in creating meaningful learning experiences.

4.2: Theme One: Nurturing the student experience.

"It's about who you are working with" (Std Aus)

The findings in this theme centre on the people and processes enabling student integration into the real world clinical setting. Typically a sequential process, beginning with students being made welcome, an invitational prelude to opportunities to engage with the team and to participate in contextualised, authentic nursing practice. This student captures the essence of this section of the findings:

> *"The best placement I have encountered was whereby I was introduced to the ward, orientation of the ward, introduced to nursing staff and assigned an RN/s who were supportive and encouraging. I really appreciate the patience and constructive feedback given. I also am grateful for the exposure and opportunities that were given, allowing me to be part of something. It was also nice to be appreciated and part of the team" (Std Aus).*

Each clinical placement occurs in a unique environment shaped by a workplace culture which is influenced by, and exerts influence on, the staff within that setting. This culture influenced students' interactions with staff, the setting and their access to learning opportunities. The brokers of student engagement, were staff in a variety of roles each student encountered, many engaged with the core business of patient care. These staff included individual nurses 'buddied' with a student on a day-to-day basis, nurse managers, nurse educators, the multidisciplinary team and patients and their families. Where a student supervision model existed, students were also assigned a mentor(s) or clinical facilitator for the placement's duration.

Students described the collective local culture, processes and procedures along with individual attributes and actions of staff as factors enabling engagement with nursing practice. These factors also emerged in the narratives of staff participants, as reflections on personal experiences or observations within their current roles. The enabling factors that contributed to positive clinical learning experiences generated four sub-themes. The first sub-theme describes how students are made to feel welcome and building from this, the second sub-theme examines how students are integrated to become part of the team. Sub-theme three considers how student engagement with learning opportunities is facilitated within the clinical setting and the

final sub-theme draws together how student exposure to learning experiences might be enhanced.

4.2.1: Being made to feel welcome

An association between the culture or philosophy of the ward/unit and how students were welcomed by facility staff was noted as a strength by student and staff participants. This staff member at Site 1 recounts the *"huge spectrum"* in the reception students may receive:

> *".....if you walk through a ward and go 'hey these are my students for the week isn't this fabulous', like welcome with enthusiasm and really positive or if you walk into a ward for half an hour with your bag on and no one even says hello to you and it's like 'huh students you have got to come and work with me for the day'.... and I've witnessed both of those..." (HEI Aus).*

Some student comments evoked a sense of relief, as though being welcomed was a crucial first impression of staff enthusiasm for hosting students and whether the experience would be a positive one. This initial reception was a prelude to how the placement would unfold legitimising the students' position as curious, engaged learners. Welcoming environments could be those where the shared values and beliefs of staff were evident in the atmosphere the staff co-created. This communal approach was tangible and students entering such settings noticed the *"atmosphere of utter positivity" (Std UK)* or found *"the philosophy of this particular clinical area made it a pleasure" (Std UK)* to work in.

Considered pivotal in promoting a vibrant learning culture was when *"the lead person in the team [was] really focused on learners".* Many participants believed those in leadership roles such as nurse managers or nurse educators influenced the adoption of a negative view of students. If this lead role was "*not interested in learning"* then the *"placement [wasn't] interested in learning" (HEI UK),* as this academic also described:

> *"...the senior person I think they have huge influence and if they at all put across a message that students are a…nuisance then it filters down ....absolutely it does" (HEI UK).*

A key person could be influential and where good relationships existed, a cascade through all nursing staff could create a pervasively positive and supportive atmosphere with willingness to engage and teach students:

> *"……if they have got somebody who has a definite, almost an ownership of students learning 'Yes we want this to be a fantastic experience and I am going to work with my team to make it a fantastic'… So I think if there is*

someone like that it helps to influence the whole culture of the ward" (HEI UK).

The positive effect a clinical nurse leader had on creating an environment receptive to students is reinforced by this student's comment:

> *"My worst placements have been when the NUM on the ward is disinterested in students. RN's pick up on this very quickly and treat you the same way" (Std Aus).*

Several academics reflected on nursing culture in general and the notion of "*nurses eating their young" (HEI Aus)* as being ever present. Consequently, one academic's dream was *"…to have every placement the student went to, the staff were supportive of students" (HEI Aus)* even with the pressures and stressors within the healthcare setting. In reality, there were unwelcoming environments where staff were "…*negative and unkind to students"* and student supervisors needed to teach "....*students how to manage people and staff" (HEI Aus)* in order to build resilience.

Several students observed that when staff worked in supportive environments this influenced their interactions with students. On placement in a private healthcare facility, one student perceived a less stressful environment meant staff had *"… been friendlier than in the public system"* which created *"a domino effect for when they're teaching students" (Std Aus).* Simple actions could signify a friendly or welcoming culture. As this student described their best placement as one where she was treated as an individual - "*I was introduced to the ward, introduced to nursing staff" (Std Aus).* The importance of individual recognition is echoed by this UK academic's comment for students *"not to be [referred to as] "….'nurse' or 'student' can you….."* due to staff "…*not knowing their name after 8 weeks" (HEI UK).*

Many students associated a positive placement experience with an initial welcome followed by a thorough orientation. This helped students appreciate what they could expect to *see* and *do* on placement and to situate the setting within the wider context of the multidisciplinary team, health service and other aspects of care delivery. As this student described:

> *"I had a great orientation with [named] MH team. I was able to understand how the services ran and knowing what to expect on that placement" (Std Aus).*

Another student described how an effective orientation was a factor that worked well in helping them feel prepared for their placement:

> *"The ward had an educator who made a 'cheat sheet', which was a brief run down on the usual conditions seen on the ward, care required, possible*

> *complications, contact numbers…..As we were given this on the first day it made us feel more up to speed with what to expect" (Std Aus).*

Positive ward cultures generated a sense of inclusiveness with students considered a resource, with something to contribute. Academic staff felt these environments were committed to developing *"students as the future workforce" (HEI Aus)* and ensuring students had meaningful clinical experiences was important in sustaining the profession:

> *"....if the nurse educator and the CNC and the NUM are very inclusive and have a positive outlook on developing the next generation of nurses...they [can] view them as a burden and it's like well we have to take these students or it's like we really want to involve them as much as possible and have a really positive placement" (HEI Aus).*

Another academic also captured the significance of the culture people create in the healthcare workplace:

> *"I don't think it's the setting, I don't think it's the bells and whistles I think it's more about students feeling a sense of inclusiveness as opposed to being excluded from the culture of the facility. I think it s more about people making connection with other human beings and that being a positive experience, feeling like they are being listened to and valued and they feel confident in asking questions..." (HEI – UK)*

A welcoming and inclusive culture was also critical for the Clinical Facilitator model of student supervision. As visitors in the facility, how facilitators were perceived and their relationship with staff could influence the welcome students received. When facilitators worked consistently in one or two facilities they built rapport with staff, however, as this facilitator commented it *"…took time for staff, nurses and NUMS to 'suss you out' and get to know you".* This was worthwhile as this facilitator noted once you *"win them"* the staff *"accept you as one of them" (HEI Aus).* These relationships could be influential and facilitated access to learning opportunities including admittance to other departments, for example, emergency, attending doctor's rounds or on site education activities to benefit students.

4.2.2: Becoming part of the team

Being welcomed, introduced and orientated to a placement setting, enabled students to *"feel like part of the team"* and enhanced their learning experience. Whilst students were paired with a mentor or buddied each day with an RN, the multidisciplinary nursing, medical and allied health team, contributed to the overall placement experience. Students referred to this in a person-centered way, using the collective term 'the team' or geographically, as the 'ward or unit'. Students made numerous references to being part of the team, being part of a shared experience, and part of a community and perceived this as a privilege.

Teams are defined by key characteristics such as shared goals and values, mutual respect and benefit and members of effective teams support each other contributing to their overall success, which was noted by students:

> *"Everybody worked together as a team, it seemed to be a very democratic approach as everybody was treated equally and was able to share ideas with each other openly and help each other out" (Std UK).*

When members of the ward team supported each other and worked effectively together this was reflected in the overall culture of the clinical setting. The inclusive team worked collaboratively and students described teams that *"worked incredibly well together and [were] always coordinated well" (Std Aus).* Well-functioning inclusive teams could make students feel connected and *"part of their team"* (Std Aus). In a respectful culture, for this student, nurses were seen as a *"role model and an example of good practice"* which *"meant my learning experience was excellent" (Std UK).*

Being part of the team could be a powerful influence on student motivation. This student at Site 2 eloquently captured this, describing their sense of responsibility to 'give back' to a team which had been proactive in meeting their learning needs:

> *"Working in the labs for procedures such as angiograms and PCI - the team were fantastic and made me feel part of it - not just a student. All talked to me like a person and made me feel welcome and all wanted to teach me - not just the nurses. It made me want to learn more so that I could understand what they were all talking about" (Std UK).*

Other students welcomed the opportunity to identify with the team, to feel useful and participate in a meaningful way, such as contributing productively, helping the team "*manage the patient load*" *(Std Aus).* Students reported that "*it was nice to be appreciated*" *(Std Aus)* and to "*feel like a valued member of the team" (Std UK).* Valuing students as learners "*rather than the unpaid help*" *(Std UK)* further legitimised their emergent place in the clinical team.

When students referred to the 'team' whether this extended beyond the nursing team was not always explicitly stated, though several students did refer to the value working with the wider multi-disciplinary team (MDT). Students felt effective communication and interaction with the MDT was important for their *"professional development and preparation for being a qualified nurse" (Std UK).* In addition, being utilised as "*part of the multidisciplinary team, not just as a student*" *(Std Aus)* enhanced some students' engagement with the team. Similarly "*having other members of the MDT…..open to teaching nursing students also made it enjoyable" (Std Aus)* and

acknowledgement from non-nursing staff - "*the doctors acknowledged me" (Std Aus),* could further contribute to positive experiences.

Understanding a student's need to be part of the team resonated with academic staff when recounting feedback from students. This comment highlighted the connection extended to the student when they felt able to contribute to the team:

> *"…being part of the team is a really big thing for them, cause they feel like they are wanted and needed on placement they are not just another number, or someone there just to watch. They want to be part of it and be involved in the team" (HEI-UK).*

In addition, a socialisation element inherent in being part of the team could further contribute to positive experiences:

> *".....if they feel valued and part of the team hmm that's where I think they have a really good experience. If they are not taken to breaks with the other staff or the staff have a drink and don't sit with the students those are the things that make a bad experience. So having a drink with everyone else……being involved in the team work and the discussion" (HEI UK).*

Staff recalled their own student experiences and desire to be embraced by the team. This academic at Site 2 reflected:

> *"I remember as a student nurse I got a placement and I thought 'oh that's really high tech area and I'm going to learn loads' but the team weren't very friendly and I never really felt part of the team……."*

When students work with staff who are interested in their growth and development, this created a vital connection turning potential learning opportunities into a positive learning experience, as the same academic concluded:

> *"...you might be in the most wonderful clinical learning environment, but if the people you are with don't make you feel like you are part of the team and don't nurture you then I don't think you can learn anything.... (HEI-UK).*

4.2.3: Facilitating student engagement with learning opportunities

Being welcome and part of the team were important factors as students settled into each new placement. However, whilst learning opportunities potentially existed in all placement settings, students' access needed to be facilitated in a stepwise process. Where a receptive and supportive environment existed, students were embraced into the team, nurtured and encouraged to engage in, and contribute to, authentic practice. Particularly noted at the UK site,

students associated staff who were *"very supportive and encouraging of their students" (Std UK)* with positive experiences.

Over time, students were granted increased responsibility for patient care or managing a patient load, crucial steps in consolidating individualised learning and knowledge generation. Hence, facilitating student engagement with learning opportunities could be seen as comprising three inter-related stages:

I. Recognition of student nurses' status - "treated like a student nurse that does nurse activities and not sitting around covering for staff that are sick or absent" (Std UK);
II. Meaningful involvement in patient care - "being involved in decisions and having your opinion valued, rather than being ignored as you are 'just a student'" (Std UK); and
III. Taking on responsibility for practice with increasing autonomy – *"I felt that this particular placement gave me more responsibility than other placements" (Std UK).*

Recognition of student nurses' status

The student nurses' supernumerary status is subject to interpretation, with a potential mismatch between, for example, the supervisors and students' understanding of the student role in the clinical setting. Staff reflected on the need to strike the right balance when interpreting and negotiating supernumerary status to ensure students engaged as learners:

> *"...this notion of supernumerary status which is a bit of a misnomer really as a student nurse I wouldn't want to be classed as supernumerary, I want to be part of the team, I want to be there looking after the patients. I don't want to be just watching what someone else is doing or made to feel like an inconvenience but at the same time I don't necessarily want to be left with a bay of patients on my own you know trying to get through my day worried to death that I might be doing something wrong. So there is a happy medium somewhere" (HEI UK).*

The potentially ambiguity of supernumerary status risked students being 'used as a pair of hands', a number in the workforce or drifting into a supportive or merely observer role. This was reflected in this comment: "*the staff in this placement didn't treat me as 'free labour' to perform tasks which they didn't want to do*" *(Std Aus).* In the UK, effective placements achieved a balance between active participation in nursing practice and supportive teaching and learning with a shared understanding of supernumerary status negotiated across university and Trusts:

> *".....we have good connections with the Trusts, so the Trusts really know our students are supernumerary and they are not just there to count as numbers in the workforce" (HEI UK)*

Students needed to understand their learner status *"...to make sure they are not being treated as an AIN and are instead being treated as a learning RN..." (Std Aus).* As many students at Site 1 worked part time as unregistered assistants in nursing (AIN's), boundaries could become blurred if students were treated as AINs rather than as a learner or adopted the familiar role themselves. This student described the predicament:

> *"....working as an AIN, I pretty much practice in a similar manner when I'm on placement. The real difference is I am allowed to think and act like a RN. And depends on which ward I work / have placement in. For example, working in an ENT ward as an AIN and a student nurse doesn't look different for me. However, having placement in a cardiac ward requires lots of clinical judgment while as an AIN I take far less responsibility. However, I still learnt more at work and placement doesn't seem like working well for me" (Std Aus).*

For this student the contribution of each experience to their development as a nurse appeared to become difficult to distinguish, particularly if more time was spent as a paid AIN role than as a student. The student who responded (n=70) to the question on whether their paid employment was healthcare related, more than half of the UK students (58%) and a majority (82%) of Australian students reported working in a healthcare related role in addition to their studies.

Meaningful engagement in patient care.

Along with recognition of their learner status, students reported the need to learn via immersive participation in patient care and associated discussion with experienced staff. One student emphasised the importance of *"inspirational"* staff that were *"willing to let students participate in clinical experiences*" and eager to *"share their knowledge"* with them *(Std UK).* When students' individual learning needs were considered and they were encouraged to construct and co-construct knowledge themselves, this created positive clinical learning experiences:

> *"The nursing staff all gave us the best opportunities to learn as much and as best as possible they allowed you to consider your own learning, and allowed you to develop your own skills by making the most of every minute while on placement there. If there was less patients on the unit on a particular day then they would utilise this to go over the way theory related to the care given and the research behind why we practice this way" (Std UK).*

Individual nurses who were welcoming, friendly, kind and connected students to the nursing world with enthusiasm and positivity were described as *"genuinely interested and very positive" (Std Aus*). These nurses explained their actions and answered questions, contributing to an environment where students felt supported and valued. Further desirable attributes valued by

students were nurses who were "*respectful*" yet used "*challenging questions to improve student knowledge, experience and involvement*" *(Std Aus)* to effectively facilitate the learning process. In addition, students appreciated staff that invested in the student's learning experience, by identifying their *"strengths and weaknesses"* and provided learning opportunities "*that cater to my scope of practice*" (Std Aus).

Identified at both sites by staff and students was the crucial role the nurse working directly with a student played in ensuring participation in enriching activities. The commentary regarding the supervisor, the student-supervisor relationship and the support and governance for supervision roles were prominent across the findings. The supervising RN - a clinical facilitator at Site 1, the student's mentor at Site 2 or an RN buddied daily with a student - could significantly influence the quality of the student experience. Students at both sites referred to nurses or supervisors as being able *"to make or break a clinical experience" (Std Aus).* As this student stated "*the most important [thing] for me is how good the clinical instructor is*" *(Std Aus)* and similarly "*the success of a clinical learning experience is down to the mentor (Std UK).*

Education staff were also cognisant of this, agreeing that "*the mentor is absolutely key"* and adding "*…the mentor is so influenced by the culture of the environment so that clinical leader…..is key because I think they have a big influence on how the mentor is..." (HEI UK).* The actions of supervising nurses in shaping relationships, access and connection to the learning environment influenced how the student engaged with, and felt part of, the nursing activity. Whatever the model of supervision, the words students choose to describe their experiences of successful supervisor-student relationships - *excellent, incredible, enthusiastic, inspirational, supportive, confident and motivated* - evoked the significance of this relationship for students.

Despite their legitimate place as a learner, it was evident, especially at Site 1, that students were guests in the clinical setting. With the exception of a final 4 week block, most placements at site 1 were 2 week blocks, offering limited time for students to access learning opportunities. The clinical facilitator, mentor or 'buddy' registered nurse were important conduits between the learner and learning opportunities and instrumental in ensuring ward staff supported and encouraged student access to patients and nursing care. When the supervisor and student 'gelled' an important relationship developed that was facilitative of learning:

> *".....developing that rapport with your mentor and vice versa is hugely important….if I come in to work as a student and I am dreading working with my mentor because we don't get on then that isn't conducive to learning.." (HEI UK).*

Students at Site 1, when describing *'wonderful'* or *'amazing'* clinical facilitators, valued capacity for the identification of learning experiences and encouraging critical thinking and inquiry into practice. Like the ward based buddy RN's and mentors (Site 2), clinical facilitators were seen as promoters and supporters of learning, but Site 1 students also described facilitators as guides and translators, assisting students to understand 'nursing' and 'healthcare'. Some students wanted more of this aspect noting that the:

> *"…facilitator's role should provide support to BN students - not only providing clinical knowledge but also advice as a nurse regarding the reality of nursing i.e. conflict that can happen between staff" (Std Aus).*

Students described inspirational and 'great' clinical facilitators who could make up for any perceived shortcomings in a placement, create learning opportunities for students and influence overall quality of the experience. One student clearly attributed what was for them, a transformative experience, as being a collaborative student learning activity, initiated by their clinical facilitator:

> *"It was a facilitator (Name) that made my most memorable clinical experience. She organised for us to have complete responsibility (within our scope) for a 12 bed unit in the facility and one of our student group nominated a team leader each day. The leader had to delegate roles and responsibilities for the shift to the team and supervise their actions. This included all aspects of patient care; personal care, meals, activities and liaising with the RN and family - it was truly a pivotal experience for me" (Std Aus).*

Whilst other factors contributed to this student's memory of the experience such as being given responsibility, taking on the RN role or delivering patient care, for this student, it was the facilitator who orchestrated this positive learning experience.

In addition to the traditional university employed Clinical Facilitator supervision model at Site 1, students described an emergent model, the Facility Appointed Base Facilitator (FAB) model. Here, the RN facilitator is a Local Health District employee and supervises students from all education providers using that facility for placements. Many of the students experiencing this model valued the 'best of both worlds' approach as "*hugely beneficial"* and felt the facilitators were *"amazing" (Std Aus)*. Like the ward based RN working with a student, a key benefit of the FAB facilitator was the RN's connectedness with the facility and ward specialty:

> *"From my experience, facilitators that work at the facility are best appreciated and accepted by the facility. I think the reason why is because facilitation is internal - so the facilitators are comfortable in the wards and are happy to teach us more" (Std Aus).*

In addition, existing relationships and insider presence made it more amenable for the FAB facilitators to negotiate with staff, which enhanced their capacity in brokering clinical experiences for students:

> *"*[FAB] *Facilitators are more involved and know the hospital better (and know the staff better). So they can help in allocating the student to the right (or better) nursing staff who is willing to teach them" (Std Aus).*

Having a facilitator who knows a particular clinical setting well also occurred in the traditional clinical facilitation model, although this could be more serendipitous, as this student observed:

> *"my (university) clinical facilitator had actually worked within the same unit that I had been placed for an extended period of time, therefore she was able to really impart valuable knowledge, and understand any struggles etc. that I may have had" (Std Aus).*

A challenge with the clinical facilitation model arose when both student and facilitator were new to a facility. Students felt that if a facilitator had limited knowledge of an area or facility, this could potentially make "it difficult (for students) to utilise them as a resource" and this was compounded "*…if they had never worked in the area (e.g. paediatrics) that they were facilitating" (STD Aus).*

Finally at site 2, the Hub and Spoke model could enhance students' access to learning opportunities but this was dependent on how the model was implemented and the level of engagement by the student's mentor. The mentor(s) and link lecturers, via their professional networks, were able to open up enriching opportunities for the student, as described here using the example of a cardiac ward:

> *"…if I have a good mentor my mentor will be thinking about things I can do in addition to just working in this ward looking after these patients, so I might have a day in theatre where I might see a coronary artery bypass being done so I can visualise what has happening with my patient, spend a day in ICU. There may be various clinics I can spend couple days in or various nurse specialists I might shadow for a couple of days to find out what they do, how they fit in, I might have a day with the physio getting the MDT angle...." (HEI UK).*

Hence the 'spokes' could make placements come alive for students, demonstrating aspects of the wider patient journey and connectedness within healthcare.

Taking on responsibility for practice with increasing autonomy

Taking on responsibility was described by several students as a further feature of positive experiences. Building a relationship with their student, the supervisor got to know the student, their ability and how much support is needed as this student described:

> *"My last placement (children's ward) felt incredibly rewarding. I think this is because I worked with my mentor most of the time and therefore developed a bond and relationship where she knew what I was capable of and felt comfortable doing but I also felt comfortable asking for help if I wasn't sure. She trusted me to practice my clinical skills on the ward and this was very rewarding" (Std UK).*

When mentors were experienced both as a nurse and mentor they demonstrated confidence in their own ability and that of the student, allowing the student to take responsibility for patient care. As this student described:

> *"The best thing was that my mentor didn't use me she actually wanted to teach me and told me I was in charge and gave me the opportunity to learn and be involved in care that I was giving and I loved it. I was given responsibility and my own patients but I wasn't given more than I could handle and still felt fully supported throughout by my mentor" (Std UK).*

The development of trust and rapport was important for the buddy RN at site 1, acting as a precursor so that "*the more they get to know you and your ability the more they are inclined to spend time with you and pass on knowledge" (Std Aus).* A factor in this was sufficient time for a relationship to develop. The supervising nurse required adequate time with a student, to establish trust and better understand the student's capability and level, in order to allow students a degree of autonomy when engaging in the delivery of care under supervision. Considerations on the duration of placements influence on students' experience of placements are further explored in Chapter Five.

4.2.4: Enhancing the learning experience – the student voice

This sub-theme considers response to the dream questions inviting students to consider what might be to enhance clinical learning experiences in the future.

The mentor role at Site 2 had links to the promotion and career structure within nursing. Students were perceptive to the impetus and motivation registered nurses may have in being mentors – assuming the role by choice or for career advancement. Students wanted to *"ensure mentors want to be mentors!" (Std UK)* and for the right reasons – *"because they want to share*

their skills and teach students how to be the best they can be not because they get paid more!!" (Std UK). This student commented on the long-term importance of effective mentorship:

> *"Clinical areas should ensure the people who are mentors are the right people to be teaching the next generation of nurses and student nurses should be able to feedback about the quality of their mentor on each placement" (Std UK).*

At both sites the need for adequate supervisor preparation and support for supervisors was proposed. For example, at site 2, it was suggested mentors needed *"up to date mentor training each year"* (Std UK), for updates, such as documentation changes. In addition, students wanted *"more ongoing monitoring of facilitator performance"* (Std Aus) for quality assurance and accountability for the role. Ensuring mentors were not overburdened with students was another consideration, to ensure sufficient time to engage with each student.

The supervision model at Site 1, with RN's employed casually as clinical facilitators, had its own unique challenges and complexities. One student's sentiment was that *"facilitators seem to be hit and miss"* (Std Aus) suggestive of varied experiences of the role. Another student commented that *"there is too much inconsistency in expectations"*, proposing the need to enhance the uniformity in the implementation of the role. Three main factors influencing these perceptions of the clinical facilitator role emerged. These were the model itself, opportunities for student-facilitator contact and the clinical versus educational experience of the facilitator.

In the clinical facilitation model, the facilitator is expected to be many things for the student, a guide, teacher, student advocate and assessor, contributing to a potential mismatch in expectations, both the facilitator's expectations of the student and the student's expectations of the facilitator. Students wanted a strengths-based approach and to have *"more supportive facilitators rather than adversarial"* and for facilitators to *"encourage students rather than threatening them with failure"* (Std Aus). Students could feel that facilitators *"spend their time testing you to find what you don't know - rather than focusing on strengths"* (Std Aus). However, facilitators referred to their desire to get the best from the student and support student development to the required level.

The second factor was students wanted *"facilitators (to) spend more time working WITH students on a ward"* and *to "encourage facilitators to work with the staff and students"* in order to get to know the student and *"really see how they interact"* (Std Aus). There was a desire for facilitators to be more available and more proactive in relation to teaching and directly evaluating student skills. In part, this was related to students either having limited time with their buddy RN or uncertainty about asking things of the 'buddy' nurse they were working with:

> *"Have facilitators who are willing to go through things that the student doesn't understand and the nurses don't have time to explain" (Std Aus)*

The third factor influencing student views was students wanting facilitators to ideally have knowledge of the facility and have "*direct experience in the particular area/specialty you are placed*" *(Std Aus*). For example, one student suggested having an 'expert guide' beyond their buddy RN, for example *"mental health nurse supervising mental health placement" (Std Aus).* This was to assist students to interpret what they were seeing and doing and provide an enriching commentary on nursing and healthcare practice. Consequently, this student's suggestion was for a hybrid model with joint support from the facility and the university:

> *"Have both facilitators one from Uni and one from hospital that I'd be having placement and them work together and be group meeting together" (Std Aus).*

When the student was welcomed, assimilated into the healthcare team and connected to clinical learning opportunities, 'doing nursing' in the real world became their next focus.

4.3 Theme Two: Contributing to the practice of nursing

"There is nothing more valuable and informative than a real life situation for learning" (Std Aus).

As described in theme 1, access to learning opportunities may be influenced by individuals, the ward or unit level culture and organisational structure and policy. As temporary visitors or guests in clinical settings, students were dependent on the people they encountered who acted as gatekeepers to enriching learning experiences and their guides in navigating their placement. Access to meaningful engagement and being allowed to practice, with repetition to refine skills appropriate to their stage of development, was highly valued by students.

Within this theme are two sub-themes. The first sub-theme conveys students' sense of 'doing' nursing and the second sub-theme centres on the importance of real world experiences. Whilst the student voice is predominant, academic and professional staff contributed to these findings.

4.3.1: 'Doing nursing' – engagement in nursing practice

Access to appropriate learning opportunities was a prominent aspect of clinical placements with some students indicating a strong preference for a practical approach to their learning. In describing what they valued about clinical learning experiences, students wanted opportunities to practice, to be 'doing' and contributing to 'nursing'. Frequent use of the words 'practice' and

'hands on' indicated the students' desire to participate in authentic nursing practice, the focus of this theme.

Evoking the so called theory-practice gap students described being 'taught' in the classroom or clinical laboratory and having *"the opportunity to put theory into practice"* on placements. Others described how *"theoretical knowledge...[though] extremely valuable, it is not applied and solidified during lab sessions as it is during clinical placement" (Std Aus).* There was a sense of a translation occurring, whereby students felt *"hands on experience"* brought their *"theory into real life experience" (Std UK).* In taking something learnt and switching to another medium, students made connections and 'saw' how theory aligned with and supported practice. *Placements provided "plenty of opportunity to put skills into practice*" indicative of the repetition required to "*develop those skills throughout the placement" (Std UK).* Most frequently students commented on developing clinical or procedural type skills "*like medications, fluids etc."* as these were *"so useful and have helped so much in confidence and learning" (Std Aus).*

For many students this sense of 'doing' inferred a preferred learning style. Often referred to as being 'hands on', this suggested the embodied learning associated with the tactile, sensory and haptic aspects of nursing activities and skills. This extended to the emotional, attitudinal and 'feeling' responses students experienced as they encountered authentic healthcare practice. Learning by active engagement and participation was particularly pervasive in the data from Site 2, as represented by this student:

> *"I learn much better when I'm hands on, seeing skills being performed out there in practice I find them much easier to understand and learn" (Std UK).*

Some Australian students also felt they learned differently in the clinical setting for example stating "*I learn more when I am practising hands on skills" (Std Aus).* Students also associated *"doing something*" and their ability to then remember the skill or activity. The findings show that many students associated opportunities for repeated practice with gaining confidence in their own abilities:

> *"Being able to reinforce and put into practice my learning as well as gaining confidence and experience in the clinical setting" (Std UK).*

Confidence, along with sufficient skill acquisition, was important for student progression as the novice nurse rehearsed for their role as a newly qualified nurse. Important in building students' self-confidence was positive reinforcement received in the form of feedback, one-on-one with their supervisors:

> *"Practicing then sitting to evaluate how you have done and looking at ways that you can improve and gain more confidence with support from your mentor and other colleagues" (Std UK)*

In positive clinical learning experiences "...*where you alone are paired with a nurse to guide you" (Std* Aus)" the supervisor could ensure constructive feedback occurred, for example:

> *"The best experiences were when your RN allowed you to perform your role with the patience yet interacting to develop your skill and understanding. Questioning why you were doing things and adding constructive and learning tools along the way" (Std Aus).*

This contrasted with the feeling some students had that university based laboratory sessions did *"not allow one on one learning for better critique and provision of learning*" and sufficient time to practice and gaining personalised feedback on their skill acquisition was limited.

Gaining confidence afforded students increasing opportunity to participate, to feel of value in the workplace and to contribute directly to patient care. This student's comment captured the feelings of the novice student with fledgling confidence:

> *"….I will never forget the first time I did obs on a real patient, I could hardly breathe I was so nervous" (Std Aus).*

However, over time as students engaged in practice with feedback from experienced nurses, they developed "*increasing confidence on the ward*", prompting this student to state that "*even though I'm finished, and I feel totally unprepared for new grad…..I can see how far I've come from my first clinical" (Std Aus*).

Several students described specific scenarios where the placement provided opportunities to develop specific skills. These included high work flow areas that drove students to develop their time management skills or areas where students could consolidate their learning and deliver total patient care. An example was ICU placements, which provided opportunities to practice holistic patient assessment and management as exemplified in theoretical components of the nursing program, as this student described:

> *"…because everything we ever learnt in our degree was practiced in this setting. The ratios were one on one, which meant you could care holistically for the patient and do the things you were meant to, for e.g. 2 hourly eye care. Not much of their care, if any, was forgotten or delayed. The staff were lovely and engaged with me and enjoyed sharing their knowledge. There was also a variety of patients and case studies that were really interesting and foreign to me. Loved it" (Std Aus).*

It was also evident that episodes of practice drove the need for theoretical input. One UK student for example had been *"taught to take blood gas"* but did not "*understand how to read one"* and wanted to ensure *"more time to have the theory behind things explained".* Making these connections to the theory underpinning practice could further inform student's clinical experiences.

4.3.2: Reality – authentic practice as a driver for learning

The notion of 'doing nursing' is expanded within this second sub-theme, which considers the constructs of reality and authentic nursing practice threaded through many aspects of the students' narratives. The theme captures the students' views on the distinctive essence and significance of real world experiences and the influence on their development. Also reflected are the variances between the taught versus real world phenomena of nursing, as experienced by students. The wider drivers and challenges of providing authentic clinical experiences in nursing programs are further explored in Chapters Five and Six.

Students valued practicing nursing in authentic real world situations. Immersion in clinical settings made the theoretical, technical and attitudinal foundations of the developing nurse come alive. As suggested by this student, involvement in authentic activities and interactions revealed the complexity of the clinical setting, which could not be taught or recreated in totality in a classroom:

> *"Nothing but real life clinical experiences can prepare you for grieving families, cleaning up diarrhoea, dodging a swing from a mental health patient, inserting a female catheter, removing wound drains.... etc. etc." (Std Aus)*

Students noted the diversity and unpredictability of the clinical workplace with the potential for unplanned or emergency situations. Added to this were less tangible elements of practice such as the interpersonal dynamics and the sense of the responsibility as a nurse:

> *"The benefit from the extra placements and experiences gives you the 'pressure', human patient interaction, curve balls and responsibility which is just not there in simulation" (Std Aus).*

Interactions with real patients were considered essential to develop fully as a registered nurse. In considering if clinical experiences offer something unique, for this student it was "*contact with our clients is the reason I wanted to be a nurse"* adding that "*this can't really be recreated in other ways*" *(Std UK).* For others, the potential challenge of each person-to-person interaction were unique noting *"it is easy to do observations on a simulator mannequin in comparison to a*

moving child who refuses to stay still" (Std Aus). Even when students had excellent skill sessions they reflected that *"it is not on real patients and does not mirror real experiences"* because *"there is no interaction and communication required" (Std UK).*

Working with real people also allowed students to encounter challenging situations. For this UK student end of life care generated *"the sense of privilege"* having become "*part of someone else's life in their remaining days*" *(Std UK).* Though challenging, these situations promoted a spectrum of feelings and responses in students, powerful drivers in developing insight into the emotional stressors within nursing and need to build resilience. As this student concluded *"you can't learn to be emotive and compassionate at university" (Std UK)*.

Within the student dialogue concerning the 'real world' were many references to the 'real' patient and the irreplaceable value of experiencing patient-student interactions first hand. Students conveyed that "*patient/nurse and ward interactions are key"* and that patients *" are not able to be replicated in a lab setting" (Std Aus).* Authentic encounters such as *"just talking with people you don't know' or "physically touching people" (Std Aus)* were considered difficult to recreate in the classroom. The many subtle nuances that made each interaction unique are captured in this student's comment:

> *"As each person is an individual, how they react to you [the nursing student] will be different, how you [the student] engage with the patient will also be different. There are also factors that can influence how you perform skills and engage with patients, e.g. a patient may be aggressive or be cognitively impaired, and that cannot be experienced nor can you really be prepared for caring for such patients, in a classroom environment" (Std Aus).*

Staff commentary echoed the students' sentiments as evidenced in this academic's assertion that *"you cannot teach reality..." (HEI UK)* and they continued:

> *"…you teach someone how to do CPR on a dummy and the reality is they may be in a pub one night…[and] someone has just slumped in the toilets at the pub after 10 pints……and you're dragging them out of there, type of thing..." (HEI UK).*

This acknowledges the reality and the randomness of the world students encountered within and beyond the clinical setting. As this academic contemplated, further strengths in immersing students into the unique clinical environment where the unpredictability and associated human factors:

> *"....it's the serendipity....that potentially chaotic environment where you cannot predict what's going to happen and you have to make clinical judgments which we can try and get students attuned to here but there is*

> *nothing like the real thing....doing CPR on a real person....comforting someone is vomiting excessively.....the cues that you pick up from the body language and the sweating and the colour changes… (HEI UK)*

A small number of students commented on valuing the role the patient/service user played in their clinical learning experiences. These comments mostly related to the satisfaction in participating in *"actual interaction opportunities with real patients" (Std UK)* and the privilege of communicating with patients. Encountering real patients helped students to appreciate the *"complexity of each patient rather than just a single diagnosis" (Std Aus)*, understand the patient's perspective, the impact of care on patients and appreciate the health-illness journey.

When perfecting the art of clinical or technical skills students noted how the subtlety of each application in the real world could differ from the controlled environment of the classroom. Examples given included one student's view that *"inserting an IDC into a real patient is a whole different story"* when compared to "*know[ing] how to insert IDC into a manikin" (Std Aus).* Whereas this student contextualised the fundamental skill of taking a pulse:

> *"…you can't understand the variations in taking a patient's pulse for example until you are in a clinical situation. Taking the pulse of an active child, a frail older person or a cardiac patient with an erratic pulse is very different to taking the pulse of a mannequin in a lab" (Std Aus).*

This was also an area where students applied their theoretical knowledge to better understand their nursing practice or adapt to the situation at hand as illustrated by this observation:

> *"There is also something about treating a real patient in a real context, the skill and associated theoretical knowledge associated with it becomes blended and actually makes sense" (Std Aus)*

Experiencing the real world of practice made some students question that "*... things we learn in university are not always how they are in reality" (Std Aus).* However, the considerable diversity of settings used for clinical placements exposed students to a wide spectrum of how skills may be implemented. Consequently the actual application of what has been learned at university and how students engage in practice could vary from placement to placement which some students found challenging, as this student explained:

> *"…have found with most practical skills I have been taught in labs, the actual experience when on a ward is completely different. Every hospital and indeed every ward and educator has its own unique way of operating more often than not, what I have learnt in the lab has had to be "unlearned" or "relearned" in a different way" (Std Aus).*

In concluding this theme, some students specifically made links between their simulated clinical learning experiences and their 'real world' experiences. Students appreciated the value of learning in simulated learning experience "*I do think simulation is important to understand basics"* but that this needed to be further consolidated with real life experiences that "*follow every simulation*" *(Std Aus).* Another student felt it was "*absolutely vital to transfer skills learnt on dummies in lab to a real patient*" even though it may be "*hard and scary"* to do so *(Std Aus).*

Consequently, in students' accounts of their real world experiences, a sense of privilege is evident, as a powerful contribution to their nursing journey. This student's comment: *"It's a bit like child birth no one can prepare you for clinical!" (Std Aus)* is a reminder that nurse education takes place across diverse, demanding and special places which some students approached with a sense of mystery for what may be encountered. This final observation by a student indicates that real world encounters could be reciprocal in nature between the student and the patient:

> *"It gives you an opportunity [to] spend time with your patients that you would otherwise not have and gives you opportunity as students to speak to your patients and find out what they would like from nurses in family centred care, before becoming the 'knowledgeable registered nurse" (Std UK).*

This student's reflection demonstrated the patient's potential role in informing the next generation of nurses and their practice.

4.4: Theme Three - The journey to becoming a nurse

> *I felt so empowered and it was the first time I thought to myself - I can do this, I'm really good at this and I can't wait to graduate" (Std Aus).*

Theme three considers the individual student's journey to becoming a nurse. Each clinical placement acts as an interim destination on that journey with potential opportunities to engage with patients, staff and practice 'nursing'. As already presented, there are multiple influences on whether the experiences each student has are meaningful ones. However, the student is also instrumental in forming relationships, engaging with opportunities and generating the motivation to drive their development. There are three sub-themes, the first of which considers the student's personal approach to learning, their preparation for their role as a learner and attitudes to maximising their clinical time. The second sub-theme explores enhancements proposed for teaching and learning within the clinical setting and the final sub-theme highlights the transformational changes that could occur when 'it all comes together'.

4.4.1: Personal attitudes and preparation for clinical learning

This sub-theme considers student and staff participants' reflections on how motivation, preparedness and responsibility can influence students' placement experiences. As the student comment below indicates, students acknowledged their responsibility in making relationships and learning opportunities work effectively.

> *"Being fully engaged in my learning meant RN's were keen to support me" (Std Aus).*

Likewise, staff recognised that students could be instrumental in maximising their clinical learning opportunities. As one academic observed, *"sometimes those students who do succeed in a placement"* do so because of their own *"personal agency" (HEI UK).* This "*personal agency*" involved students taking responsibility to *"...engage and embrace what learning experiences there are and not be negative" (HEI UK)* to achieve their learning outcomes. There were various facets to this - individual flexibility and adaptation, students taking ownership and responsibility but also enhanced preparatory activities within the university.

Positive placement experiences were influenced by a student's ability to be flexible and adaptive to their surroundings making the placement work for them. In contrast, students who had rigid expectations of their placement and/or mentor and were less adaptive, potentially benefited less. This may be related to individual learning styles or preferences as the following academic notes:

> *"I went to a ward a couple of years ago and there was 2 students both in their early 20's both had the same mentor, one had a horrific time, one had a brilliant time and she complained that clash of personalities, meaning they didn't get on. When you drilled down into it, it was all about learning styles and one wanted everything put on a plate for her, everything described to her whereas the other student was self-motivated and went off and did things and actually the problem is learning styles" (HEI UK)*

To help facilitate their engagement with staff and their integration into the nursing team being willing and "*open to adapt to different personalities*" amongst staff, could make "*it easier for [students] to approach…nurses [they were] buddied with appropriately" (Std Aus).*This student is able to identify how this is part of their developing professionalism:

> *"Placement regardless of where you go is about working in a team, whereby there are people that will be challenging and therefore it is about learning how to manage that and still have a professional relationship. This cannot be taught" (Std Aus)*

Another student showed a mature insight when considering how their presence and learning needs affected the RN they worked with:

> *"I understand that being assigned a student can be challenging at times and can impact time management of the patients" (Std Aus).*

Whilst the majority of students were enthusiastic and engaged, a lack of student motivation could be testing especially for those in a supervisory role. Factors influencing student motivation were considered to include the confronting realities of clinical practice, development of their own professional identity and the perceived constant critique of their practice. Academic staff also noted the need for students to take responsibility regarding their learning by identifying and communicating their desired learning outcomes in advance:

> *"…they say well it didn't meet my needs and you think you didn't specify what your needs were. So how will they know, so open communication" (HEI UK)*

At site 1 the student was guided by objectives in their clinical assessment document but staff wanted to "*engage the students themselves much more in owning clinical and what they learn from clinical" (HEI Aus).* This included encouraging students to identify *"their own needs"* to identify with their Facilitator or RN what they needed work on "*my time management or be more in communication" (HEI Aus).* When students indicated what they needed to learn they were considered to be open to learning and being accountable as a student. This academic described the students' responsibility:

> *"it's about the student being engaged and having an attitude and approach towards their learning which is viewed as positive. Because I think that for any staff member is trying to encourage the student and be positive and welcoming and trying to engage them, if the student is disinterested even those lovely kind nurses give up eventually……So if you can present yourself as motivated/ interested then they'll more likely help you out. It's a symbiotic relationship for it to work really well…and if one thing falls down then…" (HEI Aus).*

A motivating factor for engagement and learning was the student perceiving a clinical area to be 'exciting' or an area of nursing they had a particular interest in. This was evident in an academic's account of an elective subject (site 1) where final year students constructed their own objectives to direct their own learning in a proactive way. However, as this academic stated "*they have to know what they want to learn and how to go about it"* but *"sometimes they don't know what they don't know" (HEI Aus).* Equipping students to be able to identify learning opportunities and pursue them could potentially add to their level of interest and engagement as seen in this student's comment on a positive placement:

> *"The ward also was open to any experiences we wanted to have during our placement, we just had to ask and they would try and organise it" (Std Aus).*

The existing preparation prior to clinical and how this could be enhanced were also raised, related to skills development and researching the facility/clinical area. At both sites, clinical skills were built into taught modules and both sites had well-established skills laboratories and simulation facilities, positive assets to support skill acquisition and practice. A range of approaches including scenarios, case studies, hand over and vignettes were used to contextualise the skills and/or laboratory sessions to orientate students to the clinical setting and professional behaviours. In addition, at Site 2, there was a concentrated preparation for placement week prior to clinical. Having a similar skills review class in the week prior to placement allowing students to revisit their skills and scope of practice and skills, was proposed as an enhancement for site 1. Students at Site 1 wanted more clinical laboratory session time with "*more time in the prac rooms practicing our skills"* and *"more return demonstration of the skills and extra time for students to do different skills during the lab sessions" (Std Aus).* Coupled with this was a desire for more individual feedback or assessment from tutors so students could determine whether they were performing skills correctly prior to attending placement:

> *"I did self-practice in a lab, but it is hard to tell if I was doing ok or not without someone who can teach me" (Std Aus).*

Recording skills practiced on a *"checklist that you can then take on every placement"* was suggested as a basis for students to negotiate engagement in practice with their supervising nurses. This would *"show the facility you have been assessed capable of doing"* and if local policy permitted would *"allow you to undertake it" (Std Aus).*

Researching the Facility

Preparing for placement also involved researching the nature of the allocated facility/ward/unit. Students suggested this could be a self-directed or more formalised activity with *"pre-objectives as part of the [assessment document]… specific to the ward they are on" (Std Aus).* Some students felt, with guidance, they should take the initiative to prepare. For example, "*an introduction sheet ….including a brief run down on the specialties"* would encourage student to *"look up information prior other than just guessing from Google" (Std Aus).*

Staff gave several examples of how they provided information and motivation to students in the pre-clinical period to avoid students having "*gee why am I here*" moments on placement. This academic considered it essential to build structured preparation into teaching modules to ensure the student made the connection between the learning objectives and the value of the

learning opportunities in the clinical placement:

> *"they are required to review the….objectives, think about the place they are going, give consideration as to how those objectives might be achieved on placement, research the facility they're going to, tell me what they have learnt about the facility they are going to but in a very structured way…..For reasons of ensuring they are reasonably well prepared for where they are going.....but you cannot leave students to do that you cannot assume they would do that you must structure it in…., you must….." (HEI Aus).*

As a motivator, academics used pep talks giving student license for *"being nosy - that I tell them, is the job of a student" (HEI UK).* Reminding students of their role as a learner to be curious and engaged and promoting the value of the placement is described by this academic:

> *"I'd give my students a pre-talk…..how much it's a golden opportunity because it's like gold that clinical placement because they are so restrictive in terms of the availability and also about how to kinda be a detective and find out what goes on in the clinical setting 'cause you are there to be exposed in all sorts of things, don't just bury your head in the notes, and stand at the desk and not do anything, rather go and find out what's going on and get involved…." (HEI Aus).*

Finally, staff reflected on how daunting commencing each new placement may be for students, especially if there had been prior negative experiences. Seemingly basic information beforehand could develop the student's sense of preparedness for placement as in this comment which considered the provision of information on first day practicalities:

> *"[being] able to find out simple things like where your locker is, how to get into the ward, whether there is a dress code ....those little things that make you feel like a complete fool if you get it wrong or it make you feel 'cause you got it right you are prepared. Simple things like where to get off the bus. It may not seem much of a bother to us as they are second nature but it's absolutely horrible the first time that you doing it" (HEI –UK).*

This academic questioned if students are informed about *"real practical things that probably there might be simple rules around".* For example *"does it mean if my nurse is on the ward do I have to be on the ward with her?"* or *"what if she goes off for lunch do I have to go off for lunch?"* Whilst this would assist students to understand conventions and practicalities within the workplace, it was questioned if "*students are ever told" (HEI – Aus).*

4.4.2: The structure of teaching and learning in the clinical setting

This sub-theme emerged at Site 2 and primarily appeared to derive from the format of the current clinical assessment. Some students felt there could be a more equitable assessment

experience with a range of specified tasks for students to achieve rather than a single focused clinical assessment. One student commented that having a focused, exam-like assessment took *"the enjoyment out of placement and heightens stress and anxiety levels"* (Std UK). Rather than a 'test', other students wanted to see a continuous evaluation of practice as this was considered a more reliable and equitable measure of ability:

> *"The assessment should be done by monitoring the students' work not by have a set skill set up like a test, as the aim is to produce nurses who always do things the proper way not just when they are being assessed" (Std UK).*

Students also sought ample time to practice and develop their confidence prior to a 'test' type scenario, especially if a pass or fail was the outcome. This included guidance in the form of regular feedback on their progress in order that students could continue to develop and improve. This student's comment captured this:

> *"Practicing then sitting to evaluate how you have done and looking at ways that you can improve and gain more confidence with support from your mentor and other colleagues" (Std UK).*

Several students wanted to develop the structure and guidance for learning overall within the clinical setting. Formats suggested included optional *"workbooks based on that specific placement - e.g. meds and key words formats"* (Std UK) or clinically focused learning activities for when *"wards are quiet"* students could *"independently do some work based on their clinical placement"* (Std UK). These comments featured in the findings at Site 2 where the relatively much longer placement duration that site 1 may be a factor:

> *"There needs to be a structure to the learning on the placements, of what can be achieved and what needs to be achieved on particular placements" (Std UK).*

At site 1, placements were short and this is reflected in this facilitator's statement *"every placement except for the 4 week placement…..you are 'running' to get everything done it's just a mad race..." (HEI Aus).* Consequently, there were minimal comments in this theme at site 1 although *"more structured debriefing sessions with "skills learnt" and "skills to learn" (Std Aus)* was suggested.

4.4.3: Visualising the nursing role - when it all comes together:

This theme explores how clinical placements allowed students to contextualise nursing and the nurses' role within the broader governance structures, politics and the 'system' of healthcare. It

also includes how students see themselves within that system and their transformation in becoming a nurse.

Students used the term "*the bigger picture*", which this student interpreted as the *"clinical placement is more than just learning clinical skills",* as students were exposed to the *"healthcare structure in terms of nursing, politics, hierarchy and chain of command" (Std Aus).* There are also the opportunities afforded to work with other disciplines and, in particular, understand the roles within the multidisciplinary team and the communication amongst the healthcare professionals:

> *"…working within a hospital environment, learning to work with other staff from various disciplines and levels of experience" (Std Aus).*

Specifically related to the real life experience of nursing there were three things that students described: taking on the role of the RN*,* deciding where they 'fit' and the power of positive experiences. The clinical experience allowed students to adopt the complete nursing role *"to experience a day in the life…"* and this enabled them to *"undertake duties a qualified nurse would undertake" (Std UK)* to better understanding nursing in practice. Students used the phrase to 'act' like a nurse to describe taking on this new persona, rehearsing the behaviours, skills and interpersonal communication required of a registered nurse. There were many examples of student describing this as *"understanding of the true experience of a children's nurse" (Std UK)* and to *"feel like a nurse, in uniform"* as the real world experience distinguished *"when in uni it feels like any course with essays etc. but placement is very different"(Std UK).*

A key value of clinical placements was that students were able to visualise nursing as a whole, to 'be a nurse' by practicing that role and importantly sense the responsibility associated with the various aspects of nursing practice.

> *"I actually practiced as the same way as RN does, although I did not take all the responsibilities as RN or EN did. And I could imagine what I am going to do in future as a RN" (Std Aus).*

Students were also able to reflect on the value of the elements of their university program as they applied and consolidated their practice in the real world clinical setting:

> *"I believe the clinical side of the nursing course is the only way to know how to apply all the knowledge into practice, developing an understanding of the theory when it is applied to an actual case" (Std UK).*

When describing what was unique or valued about clinical placement, students also spoke of the more abstract nursing skills that are challenging to generate in a classroom setting but are abundant in the real world:

> *"The nursing experience, prioritisation of care - time management of daily tasks - various methods and justifications for determination of best practice…[and]… interpersonal skills, adopting the role of the nurse in the therapeutic relationship" (Std Aus)*

Exposure to a variety of healthcare settings and differing nursing fields was much valued by students and helped to affirm their choice of degree study:

> *"That we are able to see different clinical areas and for me it showed me that I had made the right choice in studying nursing" (Std UK).*

Varied experiences also exposed students to various areas of practice which was seen as helpful in determining career and employment options on graduation. This student experienced a mental health placement and "…*loved it. It confirmed my future direction" (Std Aus),* whereas this student's comment conveys a sense of anticipation of the possibilities:

> *"I think the other main benefit of the clinical placements is the variety of nursing settings you are able to experience. I was set on doing midwifery after graduating from my BN, but now am not so sure. Being exposed to different areas of nursing has opened my eyes to the many possibilities available to me once I graduate. What a smorgasbord!!" (Std Aus).*

Finally in this theme are students' expressions of their own transformation into the nurse they want to be. Affirmation of career choice is alluded to in the emotional rewards and sense of satisfaction some students described getting from or during their clinical experiences. This is how one student expressed their personal feelings:

> *"I love how it makes me feel. I feel a sense of importance like I am making a difference" (Std UK).*

Ultimately nurse education is about the journey of a novice student to a beginning registered nurse and beyond, as described by this student:

> *"It had a distinct vision that all the knowledge and clinical practice that I had obtained previously was meeting up at that point, and my understanding was increasing. This was further validated by my facilitator's positive feedback. I knew nursing was the industry that I would continue to work in" (Std Aus).*

This final comment captured the student's reflection that pinpointed the critical moment when there is a sense of everything coming together, a moment in time when they transition from student to nurse.

4.5: Chapter summary

In this chapter the central focus has been the students' experience of their clinical placements. Evident in the first theme, was the image of when it all works well and the crucial role that nurses, mentors and clinical facilitators and the wider healthcare team play in embracing students and connecting them with clinical learning opportunities. The sub-themes identified the many varied positive elements in the people and processes that facilitate these connections. Consequently, students were able to actively participate in authentic nursing practice as explored in the second theme – 'Engaging in the practice of nursing care'. The final theme in this chapter, detailed the findings related to the students' sense of transformation as they begin to identify and transition as a nurse. The theme also highlighted the role students have in making the system work and orchestrating successful learning experiences.

In the following chapter, 'Clinical Education: The organisational dimension of clinical placements', the findings related to the implementation of the clinical education models at each site are presented. This chapter includes exploration of the factors influencing the current clinical curricula designs and the complex frameworks that support clinical placement provision and student supervision.

CHAPTER FIVE: CLINICAL EDUCATION - THE ORGANISATIONAL DIMENSION OF CLINICAL PLACEMENTS

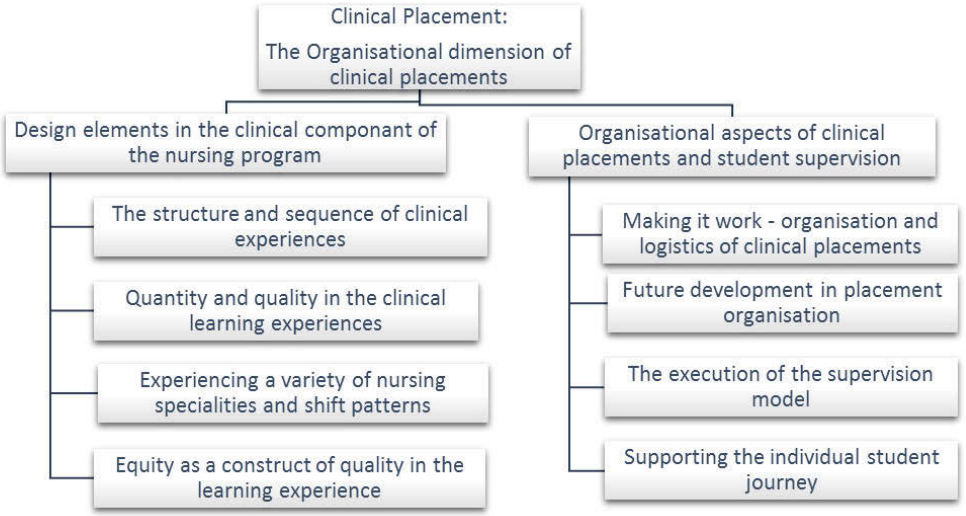
'Do not quench your inspiration and your imagination; do not become the slave of your model'

Vincent Van Gogh [11]1882

5.1: Introduction

The findings presented in Chapter Four centred on students clinical placement experiences. In Chapter Five, the findings examine the clinical education models at each site and the complex frameworks that support clinical placement provision. The structure and delivery of each model at an organisational level forms a bridge between the educational and healthcare sectors. The chapter is presented as two themes as illustrated in Figure 5.1. The first theme examines the drivers and features of the clinical component design in each program. In the second theme, the complexities of the model's implementation and organisation and its strengths are explored.

Figure 5.1: Chapter Five: Overview of the thematic structure.



5.2: Theme One - Design elements in the clinical component of the nursing program

At both study sites, clinical and theoretical elements spiral through the program, mapping the clinical component to the curriculum and students' increasing knowledge, skills and

[11] Vincent van Gogh. Letter to Theo van Gogh. November 1882 in The Hague.
URL: http://webexhibits.org/vangogh/letter/11/241.htm.

competency. The clinical component in each program is a rotational, block-based clinical education model with notable differences, as described in Chapter Three. Findings related to this pre-determined design of the clinical component of the nursing program are explored in this theme. The findings derive from staff interviews and selected questions within the student questionnaire regarding specific aspects of clinical placement design. Within the theme are four sub-themes. The first examines the structure and composition of the clinical component overall with the second sub-theme focusing on the duration of total clinical time and individual placements. The findings in sub-theme three relate to the variety of experience and shift patterns offered in each model and the final sub-theme explores issues with the equity of experience.

5.2.1: The structure and sequence of clinical placements

Structural Characteristics

A hallmark of UK preparatory nursing programs is the adult, child, mental health or learning disability field structure and its merit, along with that of the 'generic' RN qualification in Australia, were debated. Some academics at Site 2 felt without the field structure, a single 12 week child or mental health placement would be insufficient preparation to work in these fields, necessitating post registration education. Support was particularly evident for the child field as "... *one of the things we appreciate is that children in particular have specific vulnerabilities and specific needs" (HEI UK).* Several academics reported some students enter nursing expressly to become a children's nurse, hence the field approach may promote recruitment and retention. A previous RN curriculum at Site 1, offered an option for an adult, child and mental health focus in the final year so that *"...certainly from a paediatric point of view, students were much better prepared for the rigors of paediatrics..." (HEI Aus).*

For other participants the merits of dedicated adult or mental health fields were more blurred, noting that *"there are probably pros and cons" (HEI UK).* Preparing students to work with users of mental health services was supported as this involved "*more skills in working with families, and working with the law to do with Mental Health" (HEI UK).* However, as physical and psychological conditions can coexist and manifest across clinical settings, this academic, suggested nurses needed skills in both areas:

> *"I'd like to see more physical stuff in the mental health pathway and I'd like to see more mental health stuff in the adult pathway really, so I don't know if going into fields is a good thing, as you don't get someone with diabetes who doesn't have something mentally going on do you? Our wards are full of*

people with dementia so we need that cross over and things, so maybe a move towards a generic practitioner" (HEI UK).

Society and healthcare are rapidly evolving and so 'where' nursing takes place was raised. This academic considered a community nurse who may *"go into somebody's home"* who has *"dementia and they've got cancer"* and the nurse *"needs to know both".* The academic added *"there is nobody in the next ward you can shout to help you" (HEI UK),* raising the consideration for preparing students for careers in primary care/community care.

Another design consideration was the proportion of the theoretical and clinical component within a program. At site 2, the required 50:50 theory-practice composition (EU 2005/36/EC) was felt to signal the importance and connection between both components:

"...we have 50% theory and 50% practice which is brilliant because they learn the theory, background, underpinning stuff, the evidence base here and they follow that up in practice where they link it all with everything they are doing there with the service users.....and links are really strong..." (HEI UK).

An equivalent theory-practice alignment was not evident in Australian accreditation processes. At site 1, clinical placements were embedded in an associated theory module which some staff saw as strength in connecting theory to practice. Yet, from an administrative perspective, a counter argument given was this could create challenges in achieving a logical series of experiences building knowledge and skills sequentially.

Block versus rotational placements

Each site had a defined number of 'block' type placements. Students were asked their preference for block (e.g. 5 shifts/week for 6 weeks) or a continuous placement (e.g. 2 days/per week across a year/semester) and their responses are presented in Table 5.1.

Table 5.1: Student preferences for placement structure

	Block	**Continuous**	**Some of each**	**Option to choose**
Site 1 2014	5	4	6	3
Site 1 2015	11	10	5	8
Site 2 2015	13	11	5	4

NB: Some respondents ticked more than one option.

Although students in this study were familiar with block placements, some saw the appeal in a continuous placement. One student stated that a continuous placement would "...*keep all skills maintained and continually improved throughout the 3 year nurse training" (Std UK)*; this could be conducive in supporting development over time. In addition, being able to sequence the

theory with clinical experiences was *"much more appealing than blocks of learning with blocks of clinical" (Std Aus).* This student supported integration across the span of the program to generate continuity:

> *"I believe each year of nurse training should be a continuous 'placement', however the week split between clinical practice and university, as opposed to the block placement system we have now. I believe this integration of practice and theory was a better way of professional development and would provide more continuity to the program" (Std UK).*

A blended option, with an initial block placement leading into a continuous placement was suggested as students would then *"only have to do one orientation"* and would *"get to have the continuity of the facility" (Std Aus).*

At site 1 students wanted to minimise the disconnect, so as not *"learn something and then not practice it until 4 months later" (Std Aus)*. As long periods of time between placement blocks could arise, this student shared their experience, as a variant of the theory-practice gap:

> *"Too long gaps between clinical therefore you lose skills learnt along the way. Confidence drops and every time you go on clinical, you need to go back to the beginning. It is very nerve wracking" (Std Aus).*

Some students found the intensity of short block placements (Site 1) *"overwhelming"* and felt pressured to gain as much experience as possible with little *"room for rest or letting it sink in".* The following student saw *"the advantage of both options in practice"*, with a block placement supporting continuity in patient care, whereas rewarding relationships could be developed in a continuous placement:

> *"A block placement is ideal for practising continuity of care with patients on a ward over a number of days.... A continuous placement on the other hand is advantageous for developing rapport and trust within the nursing staff on the ward - a real plus on the learning side. The more they get to know you and your ability, the more they are inclined to spend time with you and pass on knowledge" (Std Aus).*

Students also considered the options in relation to balancing other competing aspects of their lives. So students may consider that a *"block placement was easier for me as I was able to take holidays from my regular job" (Std Aus).* Whilst for others "c*ontinuous would be so much better for our lifestyle, in terms of working our own jobs in order to earn money" (Std Aus).* As students had individual needs, which could vary over the duration of their program of study, some students would welcome the option to choose:

> *"Mostly for students whom have families and have work commitments. Having an option can be a life saver" (Std Aus).*

Several academic staff questioned the efficacy of the block placement design especially with frequent placements:

> *"I am not sure that our students are served well by a model that puts them out on short placements at multiple different agencies over the course of 3 years..."* for the reason that *"... students who are out for placements of one or two weeks don't have enough time to build relationships with the team, build trust, the team doesn't have enough time to asses were the students 'at' to make an informed judgement about what they can do" (HEI Aus).*

Finally, the rationale for this academic's preference for fewer but longer blocks was for each placement students were *"effectively.....starting a new job"* with all of the *"relationships that they form and settling in" (HEI UK).* Given the associated stress, longer block placements could better accommodate the time necessary for student to adjust and connect with each new environment.

Sequencing of experiences

With both clinical education models in this study, students could have differing trajectories through their program. Consequently, whether all students had a suitable sequence and breadth of experiences was raised. Some staff supported a set pattern of experiences with sufficient foundational skills acquired prior to speciality placements. At site 1, clinical facilitators felt that *"all students should come to prac on the same level"* yet it was often *"clearly evident that holes exist" (HEI Aus)*. If students had limited learning opportunities prior to commencing year 3 placements, clinical facilitators found time was "*devoted to them to get them up to par",* reducing time spent with *"other students who also equally need* [facilitator] *support" (HEI Aus).*

Students wanted the sequence of clinical experiences to align with their stage of learning, so theoretical content and classroom based skill development could be applied in the clinical setting, with skill complexity advancing in a logical progression. However, as one student proposed *"more thought needs to be given to the type of placements that students are being sent"* to ensure that the "*placement is appropriate for [the] year students are in" (Std UK).* Staff also commented on the difficulty connecting the classroom based input with clinical experiences. Ensuring students practiced skills applicable to their level, regardless of the clinical setting, could be a challenge but was necessary to avoid judgement being made about students:

> *"so that the ability of correlation of theory to practice to suit the clinical area doesn't happen, you have to look at the kind of generic skills that they are supposed to be practicing in that area. But students do get criticised I think*

for their knowledge, when, unfairly I think, because why would they have that knowledge, they haven't been exposed to it anywhere." (HEI Aus).

Factors that enabled a more prescribed trajectory included the smaller numbers in the child field cohorts and having students aligned to geographical area at site 2. In addition, 'tracking' of each student's placement history at site 2 allowed for patterns or gaps to be mapped across the program.

A final finding in this sub-theme was students and staff favouring early 'taster' placements. Firstly, from this student's perspective an early placement may confirm their choice of career:

"…we were in uni for 13 weeks before our first placement. This was difficult for me as I had no previous experience in health care and was worried about whether I would like it. Perhaps a short placement fairly early in the course would have fuelled my enthusiasm and settled any doubts" (Std UK).

For staff, early exposure to the clinical setting introduced students to 'nursing' and orientated to the role of the nurse. In addition, an early placement helped students to understand *"what their role is as the student nurse on clinical" (HEI Aus)* and assisted students to more effectively contextualise the theoretical aspects of their studies.

5.2.2: Quantity and quality in the clinical learning experience

This sub-theme relates to two quantified features of clinical learning experiences – the total number of clinical hours within the program and the duration of each clinical 'placement'.

Total clinical time

Determining an optimum duration for the clinical component of preparatory nursing programs was considered to be a 'million dollar' question within nurse education. Staff at both sites felt clinical experiences offered something unique in nurse preparation (discussed in Chapter Six), however, determining duration and quality along with the merits of long versus short placements were debated. In addressing whether there should be more or less clinical time, a Site 1 academic stated "*We don't know, who knows?",* and continued:

"I don't think we have ever had any good evidence how much clinical is required. There is no evidence that the requirement set by the board is the correct one it could be more, it could be less, we don't know .....so a model that was based on evidence about hours and best practice for length of placement and facility for placement would be really good and currently I don't think anybody has that, we certainly don't….." (HEI-Aus).

Whilst some staff at both sites felt more time would be beneficial, the imperative was to focus on placement quality and maximising the time available. As this academic contemplated:

> *"If anything it's about how we better integrate the opportunity to leverage off it more. I understand we probably cannot have more hours because of the hospital staff time but even if we have the 800 hours, how do we really make them 800 hours that count and shape the profession we want at the end?" (HEI Aus).*

Students took a considered stance, with a range of factors influencing their preferred duration of the total clinical component in their program of study. Student responses to the question: *In your BN program as a whole, would you like there to be more, about the same or less time spent on clinical* are presented in Table 5.2. The reasoning for the responses was as follows.

Table 5.2: Overall clinical time: Student preferences for the same, more or less time

	A lot more	A little more	About the same	A little less	A lot less	Total
Site 1 2014	5	4	7	0	0	16
Site 1 2015	5	14	14	3	0	36
Total	10 (19.2%)	18 (34.6%)	21 (40.4%)	3 (5.8%)	0	
Site 2 2015	9 (27.2%)	11 (33.3%)	10 (30.3%)	2 (6%)	1 (3%)	33

For students responding that they would like 'about the same' clinical time, some felt there was adequate clinical placement time, sufficient to transfer their learning to the clinical setting. The UK's 50% theory and 50% practice structure was reflected in some students' comments which indicated that the *"balance between theory and practice is about right",* and the theoretical component was *"necessary to understand the practice and the rationale" (Std UK).* Some students clearly valued clinical experiences; however, due to the complexity of full time study and juggling multiple commitments, they supported the current amount of clinical time. As this student eloquently summarised:

> *"Clinical experiences have by far the greatest impact on nurse education as a student nurse; however the system in which they exist is not optimal. Not many people are able to complete a degree without a job and clinical placements can make it difficult to work. Students such as myself, who rent and have loans, need an income.....as long as the amount of clinical hours completed is equal to or greater than that required by APHRA I see no need to increase it. If however student nurses received financial support equal to what they were missing from work I believe more would be beneficial" (Std Aus).*

A mature age student endorsed this view:

> *"It's ok to learn skills in labs, but nothing compares to clinical. That said it is very stressful as a mature aged student to juggle lots of placement and work, and meet rent. It would be nice if we got at least a little financial incentive to assist us during these times... (Std Aus).*

Students also commented on the potential benefit of financial support when considering their capacity to spend time on clinical placement, noting that "*it's very hard to manage life with full time unpaid clinical placement"* and *"more than two weeks would impact greatly on financial situation" (Std Aus).* Similar sentiments from a Site 2 student added that clinical time impacted on maintaining personal finances and could incur additional costs:

> *"Any less time would not give us sufficient time in practice, any more time may put a strain on already tight finances, as we are not always able to do bank shifts, and travel costs are often very high and take a long time to be processed" (Std UK).*

Students proposing less clinical time – only small numbers of students at both sites, indicated a little less clinical time overall. Maintaining a balance between placement, paid work and full time study was again the stated reason as exemplified by this student:

> *"It is really hard to maintain work and full-time study while dealing with assignments and other commitments in life. I think more of students work as AINs somewhere while studying full-time, but during full-time clinical placements, it is impossible to work except weekends to keep the AIN position and maintain constant income. Yet, if we work on weekends, then no time for study and assignments." (Std Aus)*

Students wanting more clinical time – in their program was the view of a majority of students, Site 1 (53.8%) and Site 2 (60.5%). For many students clinical placements were considered conducive to their preferred style of learning. *"I am a practical learner and like having hands on clinical time" (Std Aus)* and *"I am very much a visual learner - seeing something makes me remember it" (Std UK).* This student acknowledged their learning at University yet valued the opportunity to develop their skills on clinical:

> *"I feel that it should be 70% clinical placement and 30% theory. Although we do learn vital information when in university, clinical placements provide the valuable opportunity to get a feel for the job and develop practical skills that we wouldn't be able to do in university" (Std UK).*

The comment above also referred to getting *"a feel for the job",* and this student felt more clinical would expose students to the nursing role they are preparing for:

> *"Unfortunately I don't feel there is enough "real world" experience in the BN program. This is needed to equip us for our future careers, for me to learn how it would be like, to nurse" (Std Aus).*

More clinical time also allowed students "*to experience different areas of work"* to inform choices for their *"future career" (Std UK).* The total duration of the clinical component discussed above is delivered as individual 'placements' of differing durations at the two sites and forms the next thread within this sub-theme.

Placement duration

This student at Site 1, reflecting on their best clinical experience described the relationship between placement duration and ability to build relationships, access experiences and engage more fully in practice as a determinant a quality experience:

> *"My best clinical experience was the one I was dreading the most! It was a four week placement…. I was placed in emergency at a hospital I had been to for 2 previous placements, one of which was ok, the other was horrendous. I went home every night in tears, so I wasn't looking forward to spending 4 weeks there. Emergency nursing is something I never wanted to do, but being there for 4 weeks meant I built relationships with not only the other nurses but the doctors and other people in a MD team. After a month the staff also knew me, and knew I was keen to get as much experience out of the placement as possible, and allowed me to participate in everything, even coming to find me if there was something going on in another part of the department when I wasn't around. They included me in debriefings, in services and I learnt so much during that 4 weeks" (Std Aus).*

In contrast, this staff member described a student's reflection on a clinical placement which afforded limited learning opportunities. When prevailing conditions do not support student participation or meet their learning needs, even a short placement may seem too long:

> *"the student wrote in their reflection they had been on a placement for 2 weeks.....and apart from talking to patients the only thing that the student had been able to do from the student's point of view was to perform a BSL once under the supervision of a facilitator. I think it was a really sad example of how the students learning needs had not been well met..... so I'm not sure that students learning under those conditions required 2 weeks you know? When you look at something like that you ask maybe we could do something better in a simulation environment..." (HEI Aus).*

Placement duration is a prescribed parameter in clinical curricula, with duration of two weeks at Site 1, except for an initial one week and final four week placement. At site 2, placements are 8-10 weeks, therefore when considering ideal placement length students had different reference points. Student preferences for individual placement length are given in Table 5.3 and

Table 5.4 and mirror the placement lengths in the current programs. At site 1, 44.2% students wanted about the same and 51.9% little or lot more placement time, whilst at site 2 the majority of students indicated a preference for 10-12 week placements.

Table 5.3: Site 1: Student preferences for placement duration compared to 2 weeks placement.

	A lot more	**A little more**	**About the same**	**A little less**	**A lot less**
Site 1 2014	2	6	8	0	0
Site 1 2015	3	16	15	2	0
Total	**5 (9.6%)**	**22(42.3%)**	**23(44.2%)**	**2(3.8%)**	

Table 5.4: Site 2: Preferred placement duration by number of weeks

No. of weeks	**4**	**9**	**10**	**12**	**14**	**8-10**	**12-14**	**12-16**	**24**	**As is**
No. of students	1	2	15	8	2	1	1	1	1	1

There were few explanatory comments from site 1 students responding 'about the same and a little less' for individual placement duration. Reasons given were firstly, the student's level of interest, for example, *"placements were too long, especially if it was an [area] that didn't particularly interest me" (Std Aus).* Similarly, if opportunities were not pertinent to potential career aspirations, students felt for areas *"such as paediatrics or mental health"* that 2 weeks was sufficient as *"a taste for these fields" (Std Aus).* Secondly a placement was considered too long when the student felt *"it wasn't such a useful prac or it was hard to get to or just not as beneficial as others" (Std Aus).* As this student commented, a perceived lack of learning opportunities could be associated with the nature of the placement:

> *"...mental health ward can be a bit shorter as a number of them* [placements] *are outpatient unit, which means students can't really do anything to participate but can only read the notes." (Std Aus)*

Alternatively, lifestyle practicalities such as *"2 weeks is easy to get off work",* influenced the student, especially if it was felt they had "*enough time to learn the routine of the ward" (Std Aus).*

When advocating for longer placements, time to transition and become sufficiently comfortable enabled students to get the most from the placement. Despite different placement duration at

both sites, students described a common pattern as each placement unfolded. Beginning with a period of orientation, students adjusted to the placement's routine and staff before identifying suitable learning opportunities. Engagement in nursing care and practising skills followed and as students began to consolidate their knowledge and practice the placement ended, and students moved on sometimes before feeling ready to do so.

With ten placements at site 1, these periods of adjustment and settling, suggested that large amounts of 'clinical' time could be more productive, as viewed by this student:

> *"The first week of placement is primarily becoming familiar with the facility, working routine, and building confidence in practice in a new setting or after a prolonged amount of time between ward/hospital placements. It can feel like you have finally found your feet and are able to flourish and truly begin to master learning objectives, and then a day or two later the placement is over" (Std Aus).*

Even at site 2 with longer placements, students experienced this pattern of adjustment:

> *"I think the more time you spend in practice the more you will be able to develop your skills. At the moment, it can take a while to get orientated into your practice placement and when this eventually settles in you feel that your time is limited now that you actually know what you're doing" (Std UK).*

At the time of data collection, sixteen 2014 cohort students (site 1) had experienced both two and four week placements. Several students commented that *"4 weeks is more beneficial" (Std Aus)* as this influenced their ability to engage in practice and *"feel confident in skill level for most things done during an am/pm shift" (Std Aus).* This student described the impact of the longer placement:

> *"My experience of a 4 week placement……was by far a stand out of my entire degree. It was the only experience where I was able to walk out after its completion and feel thoroughly confident in what I had learnt, and ready for professional practice" (Std Aus).*

Students at site 1 proposed longer clinical placements, many suggested at least 3 weeks, some 4-6 weeks and others more frequent 2 week placements. The rationales centred on students having enough exposure and time to practice clinical skills. Students repeatedly conveyed an association between repeated practice and developing confidence which they implied enhanced their preparedness for practice as an RN.

Arguments were put forward by students for longer placements at the beginning and end of the program. Early in the program the practice routine is alien to students and thus students required time to adjust:

> *"In the beginning years, it took more time to get integrated into the ward, and when you finally did and started to believe in your own work, the placement was over and next placement would be completely different" (Std UK).*

By the final year, students understood what to expect and had more to contribute; therefore longer placements in the final year allowed students to make more effective use of their time. Further, several students considered longer placements beneficial to facility staff as it took *"a few days to adjust for both the student and surrounding staff" (Std Aus).* This additional time supported the development of productive relationships to enhance the learning experience, as this student observed:

> *"It takes a week for staff on a ward to become comfortable with you as a student and be confident of your skill level before they will trust you with aspects of patient care. Once a rapport has developed with staff, it would be beneficial to have more time to build on this and learn from the more experienced RNs" (Std Aus).*

At Site 2 with six placements over three years, several students wanted longer placements but only if they worked closely with their allocated mentor(s). The perceived risk with long placements was that mentors could 'chop and change' with students allocated to someone *"to help out"* which could affect continuity in their learning.

Independent of placement duration, at site 2 there was support for three or four shifts per week, including the option of three long shifts per week. This student wanted *"4 days only because I have to work"* and consequently did not *"get a day off for the whole placement" (Std UK).* At site 1, a majority of students indicated they wanted five shifts per week, though a few suggested four shifts per week Alternative shift patterns could give students time to accommodate activities such as study or work. A novel view linking desirable shift length to learning was provided by this student:

> *"depending on the clinical area, I believe that shifts should be based on how much you can learn in that day, otherwise you are treated as a spare member of staff and it takes away the value of your placement" (Std UK).*

In contrast to students, staff were more reflective on the drivers of clinical placement hours. At site 2, the length of placement derived from student and mentor feedback over time. In past curricula, placements were shorter but "*mentors and the students both fed back…..that actually it was too short to get to know the placement, to feel confident" (HEI UK).* In addition, accommodating the assessment process before students completed the placement, was considered challenging. Therefore Site 2 "*deliberately went to 9-12 week placements" (HEI UK).*

The perceived benefits were student assimilation into an area with mentor-student relationship development, promoting effective assessment. Site 2 staff noted students only had six placements over three years, however this was complemented by adoption of a Hub and Spoke model.

From their hub or base placement, students could engage with diverse settings and activities, follow the patient journey and interact with members of the MDT *to "get a better picture of care not only nursing" (HEI UK).* The Hub and Spoke model was considered "*a massive part of (students) being able to get a view of many different areas"* and "*…definitely enhances the quality of the experience they get" (HEI UK).* When effectively implemented the 'spoke' experiences allowed students to gain a *"wider view of what's going on".* In less traditional placements settings, for example out-patients or health visiting, staff perceived that students could find the placement afforded limited learning opportunities and the spokes augmented these experiences The student's mentor was integral in supporting this process, releasing students from the placement and ensuring the spokes were relevant.

At Site 1, staff supported the final year 4 week placement - *"I love the 4 weeks" (HEI Aus).* The longer placement allowed students to settle in, become part of the team, develop increased responsibility and confidence as this staff member described:

> *"I think that a 3 or 4 week block might work better for both students and facilities - it gives students time to settle in and undertake a proper role within the team. I have observed students from other unis who do longer placements and these seem to work better. The student gets quite comfortable, they are able to do more actual nursing jobs and undertake more responsibilities..." (HEI Aus).*

In addition, for staff at site 1, more time enabled them to 'diagnose' student needs, push stronger students to reach their potential and get weaker students 'up to speed', as this facilitator summarised:

> *"...I always want more time. If I had more time how much further developed could I get those students. So I would definitely say yes to more time yeah. It's just, you're …every placement except for the 4 week placement.....you are 'running' to get everything done it's just a mad race…" (HEI Aus)*

This staff member concurred, describing the challenge in assessing students in short 1 or 2 week placements:

> *"Students who are out for placement of one or two weeks don't have enough time to build relationships with the team, build trust, the team doesn't have*

enough time to assess were the student is 'at' to make an informed judgement about what they can do"(HEI Aus)

This was particularly pertinent for final year students, who this academic felt, should be integrated into the team and require less direct supervision. However, the longer placement allowed for better recognition of student issues, problem identification and remedial action:

"*…in the third year* [supervision] *should be more of a baby sitter ...rather than a hands on facilitator. So if you are having to provide this student with this, then alarm bells should be going off… particularly in the last placement, that's why I want a month you know… lets identify these problems, lets address them..." (HEI Aus).*

Site 1 staff had mixed views regarding the 10 placements across the program. Staff described students constantly being the *"new kid on the block"* so longer placements even if fewer, would mean less repeat orientations to various settings. However, an advantage of short multiple placements was the breadth of experience, a form of 'sampling' which may inform career decisions and is explored further in sub-theme 3.

5.2.3: Experiencing a variety of nursing specialities and shift patterns

The findings in sub-theme 3 relate to both staff and student views on the diversity of students' experiences. As nursing takes place in a myriad of settings, the breadth of nursing practice students' experienced varied. In addition, many nurses work a full range of rotating shifts and this sub-theme also considers students' exposure to shift work.

At both sites, students wanted to experience a variety of hospitals and nursing specialties. One student reported that *"some of my colleagues have had the same type of placement more than once e.g. older adult community" (Std UK)* and another that it was *"important students aren't sent to the same facility over and over (Std Aus).* Consequently, students had a *"...NEED to experience different wards and hospitals" (Std Aus),* with previous placements reviewed to avoid repetition of clinical specialty.

The range of placements available for site 2 students was considered an asset by staff. With access to a large geographical area, students could potentially experience a variety of acute and community settings as this academic commented:

"...students have an amazing array of placements. In all of this area there are so many things going on...across all fields and I think that works well" (HEI UK).

The smaller child field cohort at site 2, allowed for a reasonably tailored pattern of placements. Within which it was considered important to ensure that students 'saw' and understood the scope of healthcare, including conceptualising and contextualising the patient journey and understanding various roles across healthcare, as captured in this observation:

> *"…so* [students] *understood that if you are packing a child into the back of an ambulance to send that child to an Intensive care unit that you actually had some idea of what that looks like or what it would feel like so you can explain to families. For some, unless you have that you don't know how to hand a parent over to the next setting or hand them over to home or how to hand them across to a hospice setting so I think they have to know something about the totality of care context within which the children and families are surviving and moving" (HEI UK).*

Some site 2 staff wanted more than six placements overall, for example three per year and mapped to ensure variety. Whilst, a student may not experience an acute or critical care setting until year 2, the site 2 placement unit tracked and monitored each student to promote a balanced pattern of experiences over their program.

The ability to request placements appealed to many students for several reasons, including pursuing experience in areas of personal interest. This student appreciated that *"preferences are difficult to meet"* but suggested the option to, *"rank our interests or specialties"* so that *"we have a chance to experience what makes us excited" (Std Aus*). This UK student wanted to have placements that would "*enable the student to use placement to fill gaps in knowledge or experiences" (Std UK).* For other students the ability to preference specific areas would tailor placements to their preferred career pathway. At site 2, in years two and three students had placements aligned to adult, child or mental health fields and their career trajectory. In contrast, at site 1 the program could be considered generalist incorporating adult, child and mental health placements. Consequently this student described themselves as having no interest in mental health yet *"had to do 2 lots of 2 week placements"* which was felt to be too much preferring to be "*able to choose more placements in areas that interested [them]" (Std Aus).*

Across the 2 sites there was a stark contrast in the variety of shift patterns experienced by students (Table 5.5). Site 2 students, with one exception, had experienced all standard shifts with some also rostered to long day shifts (12 hours). Students at Site 1 reported placement blocks of all AM, all PM or mixed AM/PM shifts.

Table 5.5: Shift types students have experienced.

	AM/ morning	PM/ evening	Weekends	Night duty	Other, long days, twilight
Site 1 2014	16	15	0	0	0
Site 1 2015	35	31	1	3	0
Site 2 2015	33	32	33	33	15

Only three students indicated they had experienced night duty, which two clarified this was in paid AIN work. This student considered night duty a 'must have' experience in preparation for nursing:

> *"NIGHT SHIFT!! I think the biggest challenge for student nurses is if they don't have an AIN job which means they won't experience any night shift, it's quite challenging for us to keep our clinical judgment going in our first few nights because our body is so not used to it. Being an AIN and picking up ND really helps" (Std Aus).*

Students at Site 1 felt all AM or all PM shift patterns for a placement limited their experience of ward routines and ability to access some activities, particularly during all PM shifts:

> *"I would like the shifts to not be 2 weeks straight of morning shifts, regular nurses don't do this. They change them up to have rest in between. It would also give us more of a look into what happens throughout a whole day on a ward" (Std Aus).*

Students also found fixed shift patterns tiring and disconnected from the reality of rostered shift work in nursing. This comment captured one student's feelings around shift allocation:

> *"While shift work can be tiring, so can having 5 AM shifts in a row for 4 - 6 weeks[12]. You also don't see the differences between AM/PM and Night shift" (Std Aus).*

Another site 1 student saw the benefit of matching students *"...with one or two nurses willing to have the student alongside them during all their shifts".* The perceived advantages being the student would "*experience the realities of all shift work inclusive of weekends and night shift" (Std Aus)* and receive consistent supervision from the RN.

As evidenced in Table 5.5, Site 2 students undertook a variety of shifts and were expected to

[12] If several 2 weeks placements blocks occur 'back to back', site 1 students can have 4-6 weeks of consecutive placement.

follow their mentor's shift pattern giving them a rounded experience of practice across the twenty-four hour healthcare cycle. Yet, for students in this study, the pressure in juggling competing interests impacted on this, for example, child care arrangements limiting a student's ability to participate in this way. Hence, some UK students wanted to be able to organise *"a family friendly shift pattern"* that took *"individual preferences into account".* Though the meaning of this was not fully explained, factors given were the ability to choose a "*suitable shift pattern up front that fits around you and your family commitments" (Std UK)* and *"shifts that work around the student" (Std UK).* This student added:

> *"Although nursing is a 24 hour profession, people studying are not being paid and need part time jobs to support themselves, this should be taken into consideration" (Std UK).*

In relation to shifts, some staff at Site 1 wanted a review of the seemingly restrictive and "*fragmented uni-hospital system*" for several reasons. The purported pressures on securing sufficient placements warranted "*fostering a team work approach" (HEI Aus)* to open up capacity as described here:

> *"I think availability of placements that is easy to fix.....Nursing is a 24/7 job - why students only work morning and afternoon shift, and I don't get why they don't do night shift I really don't understand that and I don't understand why we don't have 24/7 placements and weekends as well and have that built into the system" (HEI Aus).*

The above quote also raised the notion of *"reality training"* where students follow the roster of 2-3 RN's to ensure they experienced nursing as would a new graduate. This academic was *"all for it"* as a prelude to working life:

> *"I do hear of new grads being offended by night shifts and the shift work…. so I am a realist I like to… be up front about it this is how it is going to be .....it's hard getting up in the mornings but that routine is lovely compared to the realities of late/earlys and working on weekends and you can't go out. That's the life of the new grad for a while, and always working on weekends and can't go out and party, do all the fun stuff….." (HEI Aus).*

Whilst it was considered that it took time to become *"conditioned to working life"*, this transition needed to occur to balance work, ongoing study and lifestyle.

5.2.4: Equity as a construct of quality in the learning experience

This sub-theme regards perceptions on equity and quality in the clinical experience, in part influenced by the number of students and each student's unique collective experience across

the program. With student cohort numbers in the hundreds at both sites, a considerable number of placements were organised each year as this comment indicated:

> *"I don't know the exact numbers...because it's frightening. It is frightening sometimes...but we do a lot..." (HEI UK)*

Consequently, a wide range of facilities, wards and departments were required to meet demand at both sites. When diverse settings were utilised for placements these could appear to offer inequitable experiences, especially if not viewed in the context of the overall program. This comment captured a possible scenario:

> *"I've two people on the first placement and one goes to a medical assessment unit, very hands on, all sorts of wonderful things and their colleague is going out with the health visitor and they are comparing notes and one's absolutely horrified at what they perceive is the lack of experience that they are getting" (HEI UK).*

The element of uncertainty in placement allocation gave scope for variability not only from placement to placement but within a placement. This academic's observation considered that within any given organisation, ward level culture may influence the quality of the student experience:

> *"'cause you can go to wards next to each other and one's brilliant, there is a real culture for learning and valuing students and the other if you gave them the opportunity to get rid of students totally they would do" (HEI UK).*

Suggested as a solution, was to have a nurse *"who takes responsibility for practice education with students,"* potentially over several wards and acts as the *"go to person for dealing with uni, the PEFs, organising placements, organising spokes, mentors etc." (HEI UK).* This role had been initiated in some UK Trusts, for example, the Learning Environment Manager (LEM). Even when a culture for teaching and learning existed, the available learning opportunities or the level of *"excitement"* could vary on a macro and micro level:

> *"That's right 100% and it's day to day, not even prac to prac, not week to week..." (HEI Aus).*

The nature of healthcare is such, that there was randomness in each student's exposure to opportunities which threatened the equity and quality of the learning experience. Describing a student's encounter with a limited learning experience, this staff member reflected:

> *"...you know that was that student's bad luck and at the same time there would be another student who had an amazing placement elsewhere. So how do you quantify that at the end of a three year program it's only hours there*

is nothing about the quality of the learning that took place in that time..." (HEI Aus).

This observation highlighted how the clinical component of nursing programs is typically quantified as a requisite number of hours and questions how the quality of student experience is captured.

At both sites less traditional placements were considered a factor that could influence the perceived equity and quality of experience. The challenge in meeting capacity *"because of the big numbers we have*" could result in students perceived to be "*placed sometimes in the most obscure places" (HEI UK).* Similarly at site 1 large student cohorts were a potential risk to the quality of student experience:

> *"…in my opinion the current model finds its very difficult to cope with the number of students we have.....we have very little control over the nature the learning environment that our students go into in a facility and because of our numbers sometimes we are more inclined to have to go for capacity rather than quality. Capacity with as many students as we have is a really big problem and unfortunately I do think that comes at the expense of quality, a lot of the time" (HEI Aus)*

Where smaller cohorts existed, for example, the child field in the UK, placement availability could centre on a more defined number of wards/departments. This supported a more tailored trajectory across the program as this extract describes beginning with year 1:

> *"…we have one placement in the community, with the health visitors, school nurses and they are often part to the health centre and go out with the district nurses and just have a good look round at community and then the other one, so more acute type, like a hospital type placement……Over years 2 and 3 we want to make sure all of our child nurses get a neonatal placement and that they get a specialist community which tends to be children outreach services ….." (HEI UK).*

At site 1, academics spoke about placements for smaller elective modules. Several participants felt that with smaller numbers they could focus more on quality, closely sequencing the theoretical and clinical experiences and included post placement reflection to close the learning 'loop':

> *"…we set up what objectives you might be looking for .....the students did that with me a week before, then contacted the facilitator, then went on clinical, then came back and we can say how was it?" (HEI Aus).*

The elective allowed for flexibility the large 'core' modules did not have as learning experiences could be tailored to local expertise:

> *"…in an elective I guess I feel there is enough flexibility to allow those* [Clinical Nurses] *to develop a package that they think will be amazing and I am happy to work with that. Rather than having to know they have done certain skills perhaps that might be required in some of the broader bigger* [modules]*…" (HEI Aus).*

With the large cohorts at site 1 and adult field at site 2 there was potential for greater diversity in placement type. Given the challenge in securing sufficient placements aligned to course content, initiatives promoting equity and minimising the impact of large cohorts were considered. Monitoring student experience to ensure that if a student had "*been somewhere that is not that ideal*" that "*they have great opportunities elsewhere" (HEI Aus),* was one proposal. Several participants felt that it was no longer always possible to match "*a [theory] module on the acutely ill adult and an acutely ill adult placement" (HEI UK).* Staff advocated for flexible models driven by learning objectives rather than bound by location and the notion that "*no that's your ward stay there" (HEI Aus).* This necessitated an approach making it clear to students that *"these are the objectives you can get here",* with learning *"collected up over the three years" (HEI Aus),* as this academic summarised:

> *"OK they are in a hospital they could go to one ward 'cause there is something major happening and they can be involved in that and take what they want from that and then go off to another surgical ward if you like and follow what they're supposed to do, follow the objectives rather than be constrained by place or time" (HEI Aus).*

Another academic highlighted the role of the student supervisor in accessing opportunities:

> *"So if [students are] in theatres where they are not going to give IM antibiotics....then their clinical facilitator ensures that they go and do it in a different environment at a different time throughout your shift. Just because you are placed in a different area shouldn't mean you get a different experience to others...." (HEI Aus).*

Enhancing the Hub and Spoke model at site 2 was proposed, as this already offered a mechanism exposing students to a more consistent pattern of experiences, for example, a 'spoke' for students on an acute ward could be a period of time within ED.

A further manifestation of equity was in the expectation and understanding of what a student should know or be able to do, in relation to the student's stage of progress, diversity within the student population and the varied learning opportunities encountered. An example, as this academic commented, was ensuring a first year is treated like a first year:

> *"I think it's having a real sense of what's reasonable to expect of a beginning student 'cause some of the feedback that students get that they tell you*

> *about, really they are being treated like they are a 2nd year or a 3rd year" (HEI Aus).*

This also applied to the student having "*proper clarity about what they do have to know"* and likewise *"what is it Ok for them not to know" (HEI Aus).* This was challenging if the student's objectives did not align with the available learning opportunities. This staff member explored an aspect of this phenomenon - the student only being expected to know and apply the theory/content that they have covered in their program:

> *"...you have to be clever to look at the generic stuff and make it applicable to the clinical setting they are going to. And that's something I think clinical facilitators often hmm comment about with the student and perhaps unfairly. They say this student [on a cardiac ward] didn't even know.....what an angioplasty was. Well the poor student hasn't even had any science so why would they know what an angioplasty is?" (HEI Aus).*

At site 1 the resultant challenge for the student's supervisor was to identify suitable generic skills that align to the student's objectives and stage of progress. The comment above highlighted that students are exposed to different clinical experiences at different times across their program of study. Hence, when the student above does study 'angioplasty' they will have pre-existing insights other students may not.

In the early stages of their program, students needed a balance between a task orientated approach and delivery of holistic care. As described below, the expectations needed to be managed when a first year student participated in holistic care, working with limited skills under supervision:

> *"I think it's really challenging, they are real people with real medical conditions so how do you put somebody in that role as a student and say we don't want you to be task focused, you are not an AIN, we want you to do holistic care. But you are not really at a level where you can do holistic care. So maybe it's about sitting with that student and saying well this is the patient let's have a look at the kind of things you can do..." (HEI Aus).*

The following clinical facilitator (site 1) took the debate further and demonstrated their thinking into, not only whether a student can perform a particular skill, but also their proficiency level. They highlighted the importance of the facilitators experience in gauging the student's ability and the potential for differing expectations:

> *"What do I want a 2nd year student to do? How proficient do I want them to be in doing that? Is it normal that I need to teach them to do a BP again in 2nd year? Whereas, some people may think it's outrageous that I'd have to teach a 2nd year how to do a BP, they should absolutely know this by now,*

> *and I am going to fail them for that. The more students you come across - it's that bell shaped curve thing - you can start to see who stands out as not fitting into that usual group, being exceptionally good or exceptionally not so good" (HEI Aus).*

An example of *"the discrepancy between expectations"* amongst facilitators was one expectation for a student to know *"the fentanyl pathway"* compared to a student at same level who "*didn't know how to take the pulse let alone a manual BP or read a between the flags[13]" (HEI Aus).* Hence the challenge into the future was seen as finding ways to clarify and balance expectations especially for new facilitators.

At site 1 Clinical Facilitators noted that the buddy RNs the student worked alongside have varying expectations of the student as this comment captured:

> *"It's not only between Clinical Facilitators, it's also with ward staff. Some are happy if the student has made a bed, does the showers, even if they are a final year students and they'd be happy if they did that for the duration of the placement and did nothing else. They'd say 'they're just wonderful', but the next person may say 'why aren't they practicing as a nearly new graduate RN, ready to make that transition?'" (HEI Aus).*

The current system for clinical education within NSW, does mean that some RNs will encounter students from multiple universities and across different years which further compounds the challenge in knowing what to expect of each individual student. To address ensuring that buddy RNs knew what the student learning needs were, newly established clinical facilitator coordinators (site 1) met with nurse managers and educators to establish site 1's expectations. Areas for continued development were considered to be empowering the student to communicate more with their RN about what is expected and the development of effective assessment documentation to support and guide learning expectations.

5.3: Theme Two - Organisational aspects of clinical placements and student supervision

Features of the pre-determined design of any clinical curricula were presented in theme 1. In this second theme, the organisational requirements for the execution of the clinical placement and student supervision models at sites 1 and 2 are explored including practical, logistical and administrative factors.

[13] Between the flags - system is a 'safety net' for patients who are cared for in NSW public hospitals and health care facilities. It is designed to protect these patients from deteriorating unnoticed and to ensure they receive appropriate care if they do (CEC 2008).

5.3.1: Making it work – the organisation and logistics of clinical placements

The findings in this sub-theme present the complexities in the coordination and provision of clinical placements from the perspectives of staff and students.

The complexities of balancing procedures and process with student needs

Staff described ongoing innovations and developments that strived to balance the complexities involved with administering clinical placements whilst meeting the needs of the student and the organisations. Illustrative of this was ensuring the unique logistics of clinical placements could articulate with wider university student management systems, described here for Site 2:

> *"...the placement unit doesn't fit with any of the structure; [named role] has a terrible job trying to get them to understand just what it is they do and how it fits with their systems. They do a sterling job, 'cause it's not easy, it's complex..." (HEI UK).*

Delivery of the clinical component in each respective program was driven by extensive 'behind the scenes' machinery and activity, not always visible to or fully appreciated by all staff and students. *"It's complex"* resonated across staff comments and at both sites *"bespoke"* software had been incorporated into the multifaceted resources required to support placement administration. Technology was harnessed to promote a student-focused approach, as both sites demonstrated examples of improved flexibility and responsiveness to students' needs to enhance their experience.

At site 1, the merit of a centralised web based booking system (ClinConnect) was debated by staff. ClinConnect was seen by some to be a restrictive system of *"numbers and spreadsheets"* which Site 1 was *"locked into".* One academic noted that a clinical area's capacity to support students was fluid due to subtleties, such as, patient acuity and skill mix which fluctuated with time and may not be reflected in ClinConnect. Hence, a centralised system could mask the day-to-day knowledge of an institution's capacity for clinical placements. A further limitation was perceived as the systems tendency to prescribe a 1:8 ratio of facilitation, requiring placement requests to be clustered accordingly. Other staff however, felt there were key advantages to the system. Its use created a connection between health and education and strong relationships had been forged from the early dialogue and collaboration in working with the new system.

Given the complexity, many processes and patterns of working had evolved at both sites, however the potential for the unexpected - cancellations, shift changes or sickness, necessitated that staff working in the area were flexible and solutions sometimes required a "*personal touch*":

> *"…there's is always something that changes and there is never the same hmmm... there is never any continuity so it would be good but as you said before when we were talking about flexibility the very nature of clinical admin is that's its always changing.." (HEI Aus).*

5.3.2: Future development in placement organisation

Students and staff proposed several areas to improve placement organisation to enhance the experience. These included the timeliness of placement notification, travel time to placement and capacity to choose or preference placements.

The timely notification of placement information was important at both sites. At site 1, many students wanted earlier notification of their placement dates to organise work, family or study commitments. Placements could potentially be offered in or out of semester, dependant on the allocation of the University's placements via the ClinConnect system. This could result in a perceived delay in confirming placement dates, a potential source of frustration:

> *"Students are still learning they have placement within a month of it starting. The current lead up to a clinical seems to be the catalyst for a lot of hate directed at placements. If I knew in July that I had a placement on X dates in November I could plan around it" (Std Aus).*

Students at site 2 also wanted to *"be given placements earlier"* so that organising *"travel, accommodation etc. is manageable" (Std UK).* Placement dates were fixed at Site 2, however, early notification of the details had been enhanced, with a targeted system and computerised support ensuring information was provided to students "*a month before but often its 6 weeks"* considered *"much better for the students*" (HEI UK). This staff member at site 2 added advising students who their mentor was in advance was beneficial as this facilitated pre-placement contact:

> *"…a mentor allocated before they start placement and it seems like it's not a big dream but things like that can make a big* [difference]- *cause a lot of students have said that's fantastic and it really helps them but it's not consistent. So they find out who the mentor is before they start, they can ring up, visit if they want...." (HEI UK)*

The distance students travelled to attend placement was dependant on the placements sourced and secured by the HEI. Students had mixed views on how far they should be expected or need to travel. Overall, students wanted placements within a reasonable distance of home or within a specified geographical location so that they didn't *"have to travel 1.5 hours daily"* as one student found that *"exhausting" (Std Aus).* Another student reported they felt *"more relaxed"* if they did not "*have to wake up too early or get home too late"* (Std Aus). However, an excellent

experience could outweigh the travel required as this student's comment about preparing for placement illustrates:

> *"...go in with a positive attitude, no matter how far you have to travel. I travelled 2 hours to one placement and it was worth every minute!" (Std Aus).*

Another aspect students perceived would enhance their experience was capacity to preference or choose placements. At site 2, students have some capacity to choose two placements, an alternate placement where students could *"go anywhere they like"* even *"do an international placement*" *(HEI UK).* The second was the final placement, akin to an 'internship' noting that students:

> "*…get a bit of a choice they can express a preference for an area that they want to work in so might say a surgical ward..... or 'I want something high tech', so they can choose a little bit so that kind a helps them apply for jobs, so they get a placement in an area where they'll be working" (HEI UK).*

At both sites, enhanced capacity for students to have some choice was a factor staff felt would improve student satisfaction overall. Hence, staff wanted to develop placement capacity *"to increase the flexibility to make changes to accommodate student needs and avoid the use of potentially limited placements" (HEI UK).*

When there was no spare capacity the option at site 2, if a student was unhappy with a placement was to swap with another student. However as students may *"not always happy to agree"* that would *"leave a student unhappy"*. This staff member concluded with current numbers:

> *"I'd say it's manageable but would improve if we did have more placements in those areas, a little more leeway and more breathing space..." (HEI UK).*

An innovative placement management system, an advance in the "bespoke" software alluded to earlier, was being developed at Site 1, to support student preferences, placement tracking and data storage. Provided they met meet the required verification checks for clinical placement, students would have "*the opportunity to select 5 preferences, 1,2,3"* which staff believed would give students "*a lot more control*....[and] *make a difference*" *(HEI Aus*).

5.3.3: The execution of the supervision model

This sub-theme draws on findings related to the execution of the supervision models. The sub-theme begins and concludes with several collective observations on student supervision that arose regardless of the model. However, as the supervision models at the two sites notably differed, the main body examines each model independently.

At both sites, the dichotomy in the supervision role was viewed as a potential source of conflict. Despite the differing constructs of the mentor and clinical facilitator models, the 'supervisor' acted as the student's supporter and assessor, as this staff member contemplated:

> *"...they shouldn't be called mentors because classically in Greek mythology mentors didn't assess.....he was there to guide and support, not to assess. So the NMC did a disservice there, as everything is 'mentorship' but it's not mentoring because they are assessing....." (HEI UK).*

Reflecting on a mentor training program one academic recalled other disciplines description of a 'mentor' which "*was very different to what it was in nursing".* They questioned how "*you've got this mentor, this kind of role model but at the same the time they've got the power to pass or fail your placement" (HEI UK)*. It was felt that the "*the classical definition of mentorship*" was not the one *"we're giving students"* and two distinct roles were advocated, mentor and assessor *(HEI UK).* The situation was similar at site 1 where the clinical facilitator was expected to develop a mutually respectful and constructive relationship with the student to develop their strengths, yet needed to balance the competing support and assessor aspects of the role.

The mentorship model

Staff at site 2 echoed student concerns that nurses could undertake mentorship without the associated desire, aptitude or enthusiasm for the role, given it was embedded into the career and promotion structure for nursing. This academic shared their views on this:

> *"In the NHS it's really everybody who's at certain grades has to do the mentorship program and whether they are suitable to mentoring or not..... So I think you can have mentors who really don't want to do the job.....they are brilliant nurses, however they are not good at nurturing and teaching.....I think that's it's not always possible to get every mentor, a good mentor everywhere. I think there is a basis of what a good mentor is - I think very good role models and people who really understand what the students' needs are, what they have to achieve"(HEI UK).*

Historically, staff perceived that those with an aptitude for the mentoring took on the role but more recently the NMC's formalisation of mentorship arose from the increased importance being placed on learning within healthcare. Consequently at site 2, staff desired *"mentors who want to be mentors"* and greater sensitivity to factors impacting the role, including being aware mentoring students added further tensions in periods of stress or low morale amongst staff. Developing clinical areas with a strong learning culture that supported both student and mentors was advocated.

A view proposed repeatedly was to have a more defined role for mentors with greater investment in, and reward for, the mentor role as illustrated by this comment:

> *"My dream point really is to allow that people who decide to be mentors or clinical educators, time, additional training and maybe enhancement in their pay..... so that we could identify the people who are good at it, who really, really want to do it and enable those that are not very good at it and do it reluctantly the option to opt out" (HEI UK).*

Attributes of a good mentor were described as being welcoming and supportive of students, a good role model and having skills in teaching and nurturing. It was considered important for mentors to understand students' learning styles and needs in order to work effectively with students. Mentors able to adapt their approach to teaching and learning, promoted a quality mentorship experience and this concept could be included in mentorship training programs to encourage creative thinking in practice. Nurses who really engaged as a mentor were viewed as committed to the role and able to enthusiastically encourage students. When students encountered 'brilliant' mentors this was associated with positive clinical experiences.

Ensuring sufficient mentor availability was a challenge and to manage this a 'coaching model', was suggested, where students work with and learn from several RN's and HCAs. These extracts from an academic's commentary on mentorship, considered what may happen when a mentor is absent, continue to propose the advantages of a team approach and conclude with the need to ensure the student knows what to expect from mentorship:

> *"How many students have I gone to see and it's like 'my mentor's off today and I don't know what to do'. And there are 3 other nurses there or HCA's and they seem to think they have to be joined at the hip with their mentor.....telling them* [students] *they have a mentor, they feel like they have to be with that person the whole time which I think is detrimental to their learning because you learn from various people and this idea of coaching with several nurses is probably a better experience.....It's possible we partly failing to tell them the realities, we need to match the realities with what we tell them to expect. There needs to be some kind of bridging between what we tell them or there is an expectation mismatch" (HEI UK).*

Allocating students a main mentor and associate or 'buddy' mentor(s) was also considered beneficial in developing new mentors. This also benefited the student, ensuring they had someone to work with if their mentor was not available, as this staff member described:

> *"…having a mentor but also an associate mentor, so if your mentor is not there you have someone else. So always having somebody help direct their learning experience. Unfortunately sometimes students have felt like they have almost been dumped on a ward and not had any direction or any*

> *contact with people to say what are you doing, what to do ... the opposite of that is what is going to enhance quality...."(HEI UK).*

The disconnect between health and education could create challenges when implementing the mentor role, for example, large numbers of RN's were mentors and as this staff member considered a range of ability amongst mentors could exist:

> *"…keeping track of all these people and guaranteeing consistency is impossible for students and I suppose they'll be the educators of the future and you get the ones who do it because it's part of their job and don't really want to do it, it's an inconvenience and most mentors are somewhere in-between those opposite ends of the spectrum" (HEI UK).*

To promote consistency, academic staff engaged with mentor preparation programs and developed connections via roles such as the link lecturer. Regular activities updated mentors to the practice curricula and promoted positive student experiences, for example, creativity in enacting the mentor role, not constrained by historical or traditional practices. Well-enforced mechanisms to ensure mentors are receiving updates were linked to staff appraisal systems, though greater attention to succession planning was considered necessary, to address issues such as staff turnover.

One staff member felt that evolution of the mentor model had shifted responsibility for student assessment to the practice setting putting *"too much emphasis on mentors".* Mentors became "*an extension of the university…..acting on behalf of the university" (HEI UK).* This may be especially so for the 'sign off mentor' who determined student eligibility to be 'signed off' to register with the NMC.

Several staff alluded to a former Clinical Teacher role which *was "…somebody who was coming onto the ward who wasn't part of the ward establishment"*. Independent of the student's mentor, this role worked with students to *"make an assessment of you and give you some you know* [feedback]*" (HEI UK).* Re-establishing such a role was considered potentially advantageous to strengthen connection between the university and clinical placement, to integrate practice and theory and provide a supportive teaching role independent of assessment.

The Clinical Facilitation Model.

At site 1, the clinical facilitator, like the student, is a guest within each facility which may be familiar or completely new to them. Facilitators were allocated work on a sessional basis, semester by semester, and needed to orientate themselves to a facility, with time for pre-placement visits to establish connections and communication links:

> *"That's a big part of the preparation going into that setting knowing who is who, where to find things so when you are taking students round you can link them to that space rather than no one knowing what's going on" (HEI Aus).*

The clinical facilitation model is premised on facilitators having access to a healthcare facility to work with students as they care for patients. This had implications regarding access, privacy and confidentiality and, as this facilitator reflected, the necessary permissions to engage may become more complex in the future:

> *"People are getting much tighter about what they consider about privacy and confidentiality and where we fit in relation to that. Even though we are going through the progress notes with permission with the student.....it could bring up more interesting times actually.* [in the future] *I think so, that sort of thing needs to be established as to what is acceptable for us as facilitators" (HEI Aus).*

To better support clinical facilitators, the findings highlighted a need for greater connection and integration into the faculty and university including, preparation and ongoing development for those in the facilitator role. The benefit was seen as attracting, developing and retaining the best facilitators. Suggested approaches for preparation included a dedicated orientation and training program, whilst others suggested an initial period of supervised practice. As this facilitator stated *"I would love to have gone with an experienced CF for a week to see how they do it"*. However, when they started they felt they *"had to find* [their] *own way"* but with *"guidance from the students"* the facilitator developed their own student-focused approach to the role. *(HEI Aus).*

Existing clinical facilitator briefing days were considered to contribute to a sense of belonging and collegiality. The days offered professional development opportunities, information sharing and networking and provided facilitators with opportunities for peer learning. Further ongoing professional development was invited in the areas of linking curriculum content to practice, supporting students from non-English speaking backgrounds (NESB) and developing feedback, difficult conversations and the art of debriefing as educational tools. An additional development need identified by clinical facilitators was their use of technologies to bridge their work between the facility and university and in accessing additional resources. Several facilitators described making personal investment to develop their own technological capacity and generate resources to utilise in practice with students.

The findings indicate that the clinical facilitator role could be isolating and facilitators wanted to feel more connected as a group with opportunities to network to share experiences, challenges and solutions. Networking was also seen as a mechanism to understand the 'lie of the land' at

different facilities and to identify who to speak to or the best approach to take in various settings to maximise outcomes:

> *"Also when you are identifying experiences for students, sometimes having contact with someone who has worked there previously they know how it goes so you are not treading on any toes so to speak …" (HEI Aus).*

Networking could occur on a more informal basis when facilitators felt their *"best placements"* were ones where they *"had the support of fellow facilitators, to bounce ideas off"* and debrief each other. These opportunities were considered *"absolutely invaluable" (HEI Aus).*

Within the clinical facilitation model, individual facilitators interpreted and implemented the role differently across the diverse range of settings and years of the program. Some findings suggested that greater clarity was needed on the implementation of the role, its responsibilities and key performance indicators. Some *"standardised practices within the clinical facilitator group"* were suggested but "*without losing creativity as everyone brings such unique skills and viewpoint to their group of students*" *(HEI Aus*).

Several staff members felt strongly that facilitation should be adaptive across the years of the program, especially so in the final year, as this staff member considered:

> *"The years are different. For example the clinical facilitator role with first years is full on but by year 3 should be standing back more, troubleshooting etc. And it varies amongst students - some are 'flying' others need help" (HEI Aus).*

Whether the clinical facilitator needed experience and/or expertise in an area of clinical practice they are facilitating was debated. In one view, the 'buddy' RNs provided the expertise and facilitators complemented this acting as advocate and support person for the student. The clinical facilitation model relied on the 'buddy' RN supporting the student on a shift by shift basis, and as this academic observed, more formalised engagement of RNs in student education may warrant greater exploration:

> *"...they spoke really passionately about wanting to invest in their role, of supporting the students and wondering if there can be a formalised buddy system set up so only RN's wanting to do it were noted as that in the hospital so you didn't get buddied with a grumpy RN who doesn't want to do it – old or young..." (HEI Aus).*

Finally, regardless of the supervision model, the wish list to enhance supervision addressed basic practicalities. For example, lockers and to have somewhere to meet with students within clinical areas:

> *"….space. that's not a corridor, the corridor is not the place for talking; sometimes there just isn't another space" (HEI Aus).*

At site 1 the visiting facilitator needed to identify and negotiate the use of spaces such as meeting rooms in the facility. The same issue, a need for *"more private places on wards where staff can take students aside"* was raised at site 2 as this narrative portrayed:

> *"The amount of times I've sat on the floor of the laundry cupboard to meet with someone is nobody's business but it's not the best. And it doesn't value their training, when you say I am just going to have this conversation in the corner….. A consultant wouldn't, a doctor would not give a patient bad news in a corridor or you'd like to think not…" (HEI UK).*

In conclusion, despite different models of supervision the mentor and the facilitator models both bridge healthcare and education. Both models have strengths, yet the findings indicate their implementation and enhancement is complex and challenging.

5.3.4: Supporting the individual student journey

Within the data multiple references were made to supporting students, often in connection with their progression on clinical placements and the program overall. Staff at site 2 described a variety of roles and mechanisms that which directly supported students. Whilst equivalent roles did not always exist at site 1, the clinical facilitator 'voice' was prominent in this theme. Support was a commonly used word in staff narratives along with nurturing as a conception of caring for and protecting students as they developed.

Recognition of each student's individuality emerged as important. Students were seen to be on their own journey to becoming a unique nurse, as this facilitators comment indicates:

> *"I think they feel heard, that I do understand them....that I do care individually about them, and that they are not one of 200 or 40 in a class…..In the clinical setting I have an enormous responsibility….. I feel like it's an honour to take them through that journey" (HEI Aus).*

At site 1, Clinical Facilitators worked with small groups of students and frequently referred to the 'individual' needs or development of the student:

> *"Because they are all individual and they have different strengths and they will all have different things they find problematic and others that won't find problematic and vice versa" (HEI Aus).*

An enhanced model of a personal tutor system was in place at site 2 which focused individual attention on students and was considered to be an asset:

> *"I think most undergrad courses are given personal tutors and it's a nominal role, but here the role is very different, the role is quite an assertive role actually, so yes I think that's a strength" (HEI UK).*

Small groups of students (site 2) were assigned a personal tutor who monitored the progress of students in their group including the review of clinical assessment documents. If, for example, a mentor raised concerns regarding a student, action planning and intense student support would be instigated by the tutor and involve the mentor, link lecturer or others, as necessary, to *"get the student up to speed" (HEI UK).* With a focused understanding of the student's needs the personal tutor could, on occasion, request the most appropriate clinical environment to support a student in practice. The small groups of students came together to provide a valuable forum for debriefing and reflection to encourage them to signpost their progress through the program, as this staff member described:

> *"It's a bit evaluative they can talk about their experience, a bit of reflection. I always try to look at the positives, and I always start I'll say we are not going to look at the negatives.....what I want to think about is your journey as a nurse, what you have learned and what's positive and what was really good about that area....." (HEI UK).*

This exercise was considered useful in generating continuity and turning negative or challenging experiences into objectives for future placements.

At both sites students were likely to encounter multiple supervisors across their program however, at site 2 the 'sign off' mentor was regarded as a positive development. The sign off mentor could *"ask the student to bring in their assessment documents that they have for the three years" (HEI UK)* so the mentor could clarify the student's progression and address any gaps prior to signing off on the student's eligibility to register. The challenge in generating continuity in student progression was also raised at site 1 where short placements and multiple facilitators were specific challenges, as this academic reflected:

> *"I don't think our students are well served by having a multitude of different facilitators through their course. I am not saying they should only ever have one but again someone who really knows the student to assess them, assess the student over a longer period of time is much better placed to firstly articulate what the students capabilities are, where they are in terms of their own personal and professional attributes. They are able to give much more detailed, deeper feedback to the student, the student is then able to trust that person more" (HEI Aus).*

At site 1, a clinical facilitator may meet a student on repeated occasions, by chance rather than by planning. When this occurred, facilitators witnessed the individual student's journey and

progression and described a pride in seeing students "*grow*" or "*bloom*". Several facilitators commented on the satisfaction in seeing students subsequently as effective RNs, educators or managers, described as one of the most rewarding aspects of the role.

The student body today is highly heterogeneous, with school leavers, mature age students, international students and students with disabilities. Consequently, a range of individual needs and complexities were identified as this description of a fictitious but typical mature student illustrated:

> *"…if you look at the attrition, one of the big things that tips them is placement but it's not just placement.....they are juggling their finances, juggling childcare, trying to have a relationship with their partner, they've got assignments due and on top of that they have to go to placement.....though you tell students this before they come they don't understand it until they experience it" (HEI UK).*

Another staff member expanded on the scenario adding in the potential for long travel times, second jobs, and other factors that test the student's commitment to completing the program:

> *"...doing a late/early you literally come home and have a few hours sleep and come back to the placement. That hour and a half* [travel time] *is based on a computer route finder and that's not always the reality of that travel, can be longer. And the money that is, the funding, I definitely feel the money that they have as degree students is really very, very minimal, and they struggle to have everything going if they don't have a second job and all this kicks in together, it really plays a havoc. They are people that might be passionate about it but they don't survive that grilling of travel and expense, family commitments and everything else that comes together" (HEI UK).*

The development of a clinical focused academic role at site 2 was a student support initiative undertaken in response to student feedback. Placement 1, year 1 had been identified as a tipping point for attrition and successful navigation of year one could result in students being more likely to complete the program. The role of the clinical academic was to contact every first year student in placement *"so every student knows that at some point someone from the uni will (visit) who's nothing to do with the trust" (HEI UK).* Their role was then to identify those who are having difficulties, as described here:

> *"…most students would be 'yeah I'm fine having a great time, my mentor is really looking after me' - that's what we would hope all our student would have, but obviously it doesn't happen. So the ones who are having problems are the ones they concentrate on as they are the ones likely to throw it all up in the air, bugger this .....this isn't for me, cannot cope with this, or I am not supported - so by concentrating on those students with difficulties, or issues we have been able to improve the experience" (HEI UK).*

The initiative was effective in reducing attrition early in the program and had been expanded to trouble shoot across other years. The clinical academic used face to face visits, telephone, txt/sms, email and social media generating a visible presence for students on placement. Even when students have no issues, staff felt they welcomed the contact with someone from the university. The long placements at site 2 meant that students could feel isolated from their peers or other support systems, even though personal tutors or link lecturers were always contactable:

> *"Going out on placement can be quite a hairy [scary] thing for a student nurse. There are things they may have thought they were going to do and it hasn't been challenged in the initial teaching, it becomes reality when they see the patients and they see the clinical area and they come to terms with what's expected of them when they are there. Sometimes that creates anxiety and sometimes they start questioning why they are here and the [clinical academics] have been really responsive and that is a real strength of our program" (HEI UK).*

Overall there was positive endorsement at site 2 for the clinical academic initiative being "a very pivotal role in supporting" students *both "helping them to learn [and], helping them to be a nurse" (HEI UK).*

Supporting students with disabilities featured in the dialogue at both sites in relation to the abilities, knowledge and skills a student needed to be able to complete a nursing program and undertake the nursing role. For students with a disability or chronic health condition, 'reasonable adjustments' could be made to enable them to meet these 'inherent requirements'. Staff at both sites described the development of systems to support students in meeting inherent requirements. Though potentially stressful for students, early identification of impediments to participate in clinical practice and progress through the program allowed for timely and proactive intervention. This staff member commented on the processes at site 1:

> *"The project has worked really hard on saying what are the inherent requirements to complete a nursing degree and work safely as an RN and being able to work with students to understand that early on and disclose an illness or disability that may or may not have an impact and may or may not require additional support" (HEI Aus).*

At site 2 all students undertake self-assessment, creating a platform for communication around any impediments for practice. Disclosing a disability was not essential under UK law but encouraging disclosure in a supportive framework, allowed for a personalised student learning plan to be developed and reasonable adjustments to be made.

> *"We encourage* [students] *to disclose at any point right from application and what we find in the UK, students won't tell you they have a disability until*

> *they know they have a place and enrol. So they won't disclose on application* [there's] *still a stigma around disability so they won't tell us but that sort of disadvantages them from the beginning as we have to get processes in place and sort funding out..." (HEI UK).*

With the student's permission communication about disability between the student, personal tutor and practice education facilitators could be geared to a successful outcome. Whilst the implementation of the inherent requirements processes and developing personal plans for students was met with initial resistance from academic staff and mentor, it was now considered to be an asset as this staff member described:

> *"Now we are in the position that students going out with a disability and they are saying this student hasn't got a* [personal plan] *can we have one please? It's brought permission giving for the student – if they are a diabetic they need regular breaks....The mentors have said it's really great having this information as to how I deal with somebody with dyslexia as I hadn't got a clue" (HEI UK).*

The initiative was *"very positively received by students and placement areas",* assisting mentors and students alike and resulting in not having *"students failing any more like we did" (HEI UK).*

5.4: Chapter summary

The themes in this chapter convey the complexity of factors influencing the provision of clinical placements and support of student supervision in two differing models. The themes examined were the drivers in the design of clinical components of nurse education programs, those embedded in the governance requirements of professional bodies, the requirements of the organisational machinery to facilitate placement provision and meet the needs of the individual student. The intricate features in the design of the existing clinical component of the nursing program at the two sites in this study have historic and contemporary constraints and understanding these influences can only develop and envisage better future design. The complexities in the implementation and organisation of the approach to placement provision at a day to day level were evident and potentially insufficiently understood. Yet these factors are further affected by the wider social and professional influencers on clinical education in undergraduate nursing programs and some of these determinants are explored in the following final findings chapter.

CHAPTER SIX: NURSING EDUCATION - CONNECTING WITH THE PAST, CREATING THE FUTURE

'They always say time changes things, but you actually have to change them yourself'

Andy Warhol[14]

6.1: Introduction

In this third and final findings chapter, wider professional and social influences on undergraduate nurse clinical education are considered. This chapter acknowledges the changes to nurse education over time, the strengths and challenges of the present and how these inform the development of undergraduate nurse clinical education into the future.

The voice in this chapter is exclusively that of academic and professional staff at the two study sites, and draws on their reflections. The chapter is presented as two themes as illustrated in Figure 6.1. The first major theme has three sub-themes. The first considers the evolution of preparatory nursing education resulting in a perceived disconnect between healthcare and education sectors and how the manifestations of this disconnect are addressed to support the ongoing implementation of clinical learning experiences. The second sub theme considers the nursing professions' role in nurturing the next generation of nurses. The third sub-theme examines the future drivers in the ongoing evolution of nurse education to meet changes in healthcare and society. This includes participants' dreams and proposals to enhance and diversify the design and implementation of clinical experiences in the future. The second theme, considers the concept of *being a nurse* beginning with a sub theme that examines the shifting image and identity of the nurse and nursing. The second sub-theme identifies the critical transition point from student to nurse, a key point for change in future preparation of nurses. The chapter concludes with reflections on what it means and feels like to be a nurse and captures the unique role of the nurse.

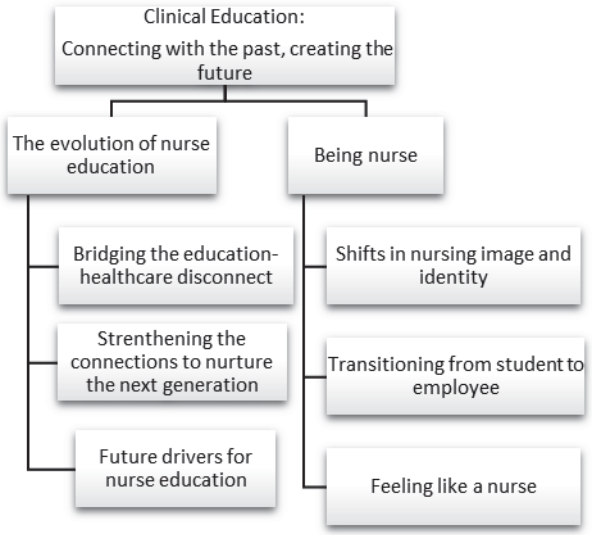
6.2: Theme One - The evolution of nurse education

6.2.1: Bridging the perceived education - healthcare disconnect

Staff participants had witnessed the evolution of nurse education, often over many years and

[14] Andy Warhol, The Philosophy of Andy Warhol, *US artist (1928 - 1987)*

Figure 6.1: Chapter Six: Overview of the thematic structure



reflected on its legacy today. This theme draws on these reflections and highlights factors emergent in the shift from an apprentice based system of nurse training to the higher education sector based professional education of today. Whilst the 'old apprentice' based system had its limitations, current approaches were also perceived to have limits, as exemplified by this comment:

> *"...historically if you look back into nurse education it sat with the clinical world, with the health service and that had its own set of problems, but I do think the holus bolus transfer of it from the clinical world to the tertiary sector is flawed as well..." (HEI Aus).*

A strength of the hospital based apprenticeship model and considered to work well was that students had a *"connectedness and a feeling of belonging" (HEI Aus)* to a hospital and by association connection to the nursing profession. The ways smaller cohorts bonded and formed long lasting relationships were also perceived to have been stronger in the past. The connections within cohorts fostered the development of friendship, peer support and opportunities for informal, yet possibly powerful, debriefing. For some academics, the experience of 'living in' nurses accommodation further contributed to the sense of belonging, as recollected here:

> *"We were better supported by our peers because we all lived in the nurses home, you know we were all in the same boat - probably on different wards but most of us were in the same hospital. So when we came back from work we went to the home, if we'd had a bad day we could go and talk to someone who understood what it meant to have a bad day, they were likely to have had a bad experience like that. So there was a great camaraderie in terms of your friends and colleagues who lived with you in the nurses' home and that's gone now" (HEI UK).*

Though not all students were required to 'live in', the shared experience described above contrasts with the options and experiences today's university based students may have:

> *"Our students are university students and don't belong to a hospital, they don't have that sense of belonging that we had and when they go home after a shift they are going home to either a hall of residence sharing with other students on different courses or they go home to their family or parents who may or may not understand what it means to be a nurse" (HEI UK).*

At Site 1, students no longer had an affiliation with a specific hospital, which was considered by this academic as *"one of the biggest mistakes" (HEI Aus).* This was considered to limit nursing students' ability to *"come and go"* between university and the clinical setting, something medical education was considered to have retained. The disconnect between university and healthcare was considered to be why "*students say they cannot link the theory and practice together",* because students saw academics *"half the time and* [saw] *clinical placement half the time" (HEI UK)*.

The sense of balance between the 'academic' and the 'clinical' was further debated in relation to the desire to produce "*a critical thinking practitioner not a critical thinking academic writer" (HEI UK).* This conflict was also evident in the attainment of the required academic standard versus the qualities perceived as necessary to be a 'good nurse'. This academic illustrated the dilemma staff could encounter:

> *"I can have a student in the classroom who I know has done all of their readings, they have researched everything really well, they are engaging, they are passionate and then hand in a piece of work and I just crumble and think I really cannot give you a fantastic mark for this even though I know you are a fantastic student and I know you are going to be a fantastic nurse when you qualify, and I struggle with that" (HEI Aus).*

Another manifestation of the perceived disconnect was a personal one, as academic staff debated how they identified with multiple roles - nurse, clinician, academic, and researcher. Some staff identified positively with being a clinician - *"I am still a clinician, I still work at* [hospital]" *(HEI Aus)* and others commented on how clinical currency and clinical connection were maintained or could be strengthened. One staff member valued working clinically each week though this could be "*very hard and it eats into my own time*" and found balancing time spent on administrative tasks "*putting grades in a spreadsheet"* with their *"passion for clinical practice" (HEI UK)* as a source of frustration.

When academic staff were able to engage with clinical practice this was considered "*really useful because you use it in your teaching all the time"*, adding that *"students think it's really good that*

you are credible and still a nurse" (HEI UK). The same academic also saw exposure to practice as a valuable means to retain clinical currency:

> *"I do half day a week still in practice.....and I've managed to keep up since I've been here, which has been really good to do. I wouldn't want to lose that – it just keeps you in touch with everything…." (HEI UK).*

In the model at site 1, the disconnect also impacted where the responsibility for nurse preparation was perceived to lie. One academic considered the student was a *"guest"* in the healthcare facility and potentially viewed by staff as *"an external person that's a burden and not my responsibility" (HEI Aus).* A combination of a disconnected system and a shift of responsibility to the university generated a lack of inclusiveness which did "*not facilitate learning.....to the extent that it could" (HEI Aus).* The Australian healthcare system was also considered to lack a *"culture of mentorship and education day to day" (HEI Aus)* within nursing and although *"every nurse is meant to teach"* some nurses were *"awful to students and don't teach them" (HEI Aus).* Consequently, the nurses taking on the buddy RN role (site 1) who are *"very good with students"* could easily become overloaded.

The transfer of nurse education to the higher education sector was seen as creating a conflict between 'student' status, and the 'professional' expectations in being a nurse. It was perceived at site 1, that students need to know *"what they are getting into",* particularly around the working conditions and being aware *"from day one they are going to be doing night shift and working public holidays" (HEI Aus).* However, as site 1 students predominantly had morning or afternoon shifts throughout their program, a student could come *"to the end of third year"* with the risk of suddenly realising *"oh I didn't think it would be like this, I was planning on a Monday to Friday job" (HEI Aus).* This academic's comment instils the desire to connect students with the realities of nursing as a complex profession:

> *"...our job is preparing students for the realities of nursing and I am sorry but nursing does not have time to be warm and fluffy with every excuse under the sun .....I believe that we need to start the way we need to continue..." (HEI Aus).*

Despite some perceived limitations and challenges created by the move from an apprentice model to being a higher education based approach, solutions also emerged from the findings. The perception that the healthcare and education elements of nursing programs were detached and lacking connection was particularly so at the student interface with the two sectors. Yet, this betrayed the existence of structures, processes and roles that worked well generating

collaborative integration of education and healthcare. Both academic and professional staff spoke to this challenge.

To promote connection, staff at site 2, described a matrix-like network between the University and the Healthcare Trusts comprising a variety of roles and processes. Integral to this network were the university's placement team, Practice Education Facilitators (PEF) and the Link Lecturer role[15]. The Trust-based PEFs provided an identifiable first point of contact for university staff and Trust-based personnel such as mentors and ward managers. In their role, PEFs became highly knowledgeable about the clinical areas as described below:

> *"So having the key person in practice who is responsible for learning in the NHS, they get to know the students really well, they get to know where the wards are that are performing well, are not performing well, the* [university] *get the feedback, they get the feedback and we can work together and we can try and then sort of improve that area" (HEI UK).*

The university hosted PEF meetings every 4-6 weeks which were considered to be valuable forums for dialogue on what was working well, new initiatives, and other updates. PEFs were also available for students and mentors, as this staff member explained:

> *"...they are absolutely fab! They have clinics in different areas of the Trust, so they go visit - just drop-ins or established days, which is a great thing for the mentors and the students. That's a big thing knowing they will be there as it helps the students prepare for placement as they know if they have any problems the PEF is there at this time..." (HEI UK).*

A Link Lecturer system was well established at site 2 and via this role academics had a visible presence in their linked clinical areas creating another avenue for dialogue and relationship building. Link Lecturers contributed to mentor updates and encountered students on placement when visiting clinical areas. Collaboration between the mentor, PEF and Link Lecturer was considered a particular strength when managing a student at risk of failing by promoting a shared approach to intervention and support.

Those with direct responsibility for placements at site 1, particularly professional staff, had developed relationships with various nurse education managers, coordinators or human resource contacts across Site 1's associated healthcare facilities. Effective relationships were based on open communication, a shared sense of purpose to collaboratively make 'placements' work to *"shape our future nurses" (HEI Aus)*. Professional staff described how the

[15] The link lecturer role is associated with support for student nurses in clinical practice and NMC standards suggest the link role should account for 20% of the university lecturer's remit (MacIntosh 2015).

implementation of a centralised placement booking system had contributed to relationship development:

> *"I think a lot of relationships were built up when they brought ClinConnect in, and they* [healthcare] *were so frustrated with it. So we were on the phone constantly trying to figure out how to make something work and you know - '…but we can't see that ...' 'Oh we need them to go there but…', 'we can't do it, you need to do it..." (HEI Aus).*

The clinical facilitator role at site 1 could be a strong networking presence between education and healthcare. At site 1, professional staff identified clinical facilitators and partners within healthcare who *"went the extra mile"* in order to make clinical placements work well. This was attributed to people who were *"passionate about….creating good nurses"* and also *"those whose main goal is about having a productive nurse workforce" (HEI Aus).* Clinical Facilitators developed an understanding of the preferred ways of working of the clinical areas, such as, the most effective ways to negotiate access to learning opportunities. However, as facilitators work on a sessional basis this could impact their connectedness with health facilities and their integration into the wider university. The recent addition of coordinator roles to support the clinical facilitation model received positive feedback. The role provided a more consistent presence in healthcare facilities, assisted with new facilitator orientation and supported facilitators in decision making enhancing consistency and quality control.

At both sites reference was made to existing links whereby healthcare staff had, for example, input into curricula design. These connections were sometimes described as *"high level industry"* links and some staff felt there was potential to *"do more joint University/Hospital development"* to harness the *"opportunities for greater collaboration and engagement" (HEI Aus).* At site 2, staff valued practitioners contributing to teaching in the classroom setting, as this promoted *"dialogue and that connectivity which is really important" (HEI UK).*

Another dialogue on connectedness came via the promotion of continuous improvement. Various mechanisms for students and staff to share constructive feedback on clinical learning experiences were evident at site 2. A university-based survey collected students' perceptions of their clinical learning environment and experiences on a continual evaluative basis. To capture real time feedback, the survey was being developed to enable students to feedback anytime rather than an 'end of a placement' approach. When issues were identified, the Link Lecturer could investigate initially and take action to enhance the learning environment, as required. Another positive initiative promoting feedback were joint university and trust feedback forums held within some Trusts, as described in this observation:

> *"The students are invited to come* [to]*…two hour slots where groups of students can come along, book into a slot. They are multi-professional and they can give their feedback direct to* [University and trust staff]*……about things they'd like to stop happening, which are probably negative things, and things they'd like to start, because it's not happening, and things they like to continue cause its good" (HEI UK).*

Inclusion of a feedback loop was a further advantage of these forums, which enabled staff to update students on how previous issues had been managed. Even if the students were not those reporting an issues, they saw that *"the last cohort said this and that this is what we did about it" (HEI UK),* so that improvements were demonstrated and communicated.

6.2.2: Strengthening connections to nurture the next generation

At site 1, for some staff, nursing education lacked a cohesive approach in its commitment to develop the next generation of nurses and it was evident in the findings that enhanced connection between healthcare and education was considered important. Revisiting a more defined and shared sense of responsibility for nurse education emerged as this academic considered:

> *"...there needs to be an overhaul of the system ..... and foster a team work approach rather than this fragmented Uni-Hospital system you've got now..." (HEI Aus).*

Site 1 academics lamented the loss of onsite clinical schools to foster healthcare-education links and clinical schools were one suggestion to re-generate 'presence' and connection, as this academic advocated:

> *"I strongly believe we need clinical schools of nursing within health services that have a responsibility for the clinical education of undergraduate nursing students. In my experience…….either within the healthcare sector with responsibility for nurse education or in the university having responsibility for nurse education, the responsibility must be shared. I believe the best model is clinical schools of nursing jointly funded by both clinical and universities, conjoint appointments with a responsibility to both worlds" (HEI Aus).*

At site 1, there was a desire to see students aligned to partnership hospitals, to develop stronger relationships and begin to nurture their professional identity. One academic proposed that there *"…needs to be a situation so that [students] apply to a uni and a hospital, and have 2 parents" (HEI Aus).* This positive approach of shared responsibility for the student was already supported in the commissioning and recruitment structure at site 2; hence each student had a relationship with a university and a NHS Trust. However, site 2 staff felt there was willingness from the healthcare sector for even greater engagement but time pressures could be limiting:

> *"In the ideal world I'd like to see us working more with clinical staff on curriculum delivery .....I know PEFs very keen to interview and they do and I involve specialists in teaching but them being able to commit to that time is difficult for them..." (HEI UK).*

At site 2 the registered nurse in the mentor role had a clearly defined role with students, yet academic staff still sought greater integration between the university and clinical sites. For example, one aspect perceived necessary was for students to see academics *"both in practice and in theory"* to appreciate the necessity to *"piece the two together" (HEI UK).* This observation evokes the theory-practice gap as a lens through which students saw their program of study:

> *"...so I would like for us in here and clinicians to feel more like a team because if we felt more like a team, the students would feel like....they don't see it as a joint course, they like being in practice, 'I'm a hands on person' and 'I have to go to uni it's more work and I don't like it', it's the theory practice gap, ever old isn't it?, but I'd like to make that better" (HEI UK).*

Another site 2 academic wanted to *"present more of a united front with practice"* as it was believed this would help students see the relationship between their course at university and being out on clinical. However, a challenge at site 2 was perceived to be finding ways to achieve this with the *"massive numbers here" (HEI UK).* Achieving greater integration and visibility was also this academics vision:

> *"...if I'm honest, I think there is an awful lot that could be done in placement that isn't--- you know and part of my vision for the future would be that there is much more of an integration between unis and trusts so that we are able to be much more visible in the hospitals - it's very separate" (HEI UK)*

Staff from both sites had a desire to maintain a clinical practice element within their role or to have the opportunity to develop this:

> *"In my perfect world – I am going to work here 4 days a week and I am going to work one day a week with the students hmm, whether its facilitating or just going in helping demonstrate or supporting the student in practice, definitely and that would be much better" (HEI Aus).*

Another academic also wanted there to be *"better systems in place to allow us to work across both* [health and education]*" (HEI UK).* One academic lamented that although they loved *"going and doing a shift"* due to the competing demands of academic life *"it just gets harder and harder to go and do" (HEI UK).*

6.2.3: Future drivers for nurse education

Nurse education continues to evolve from the present into the future and participants were mindful of other drivers in nurse education. The first perceived driver was a need to strengthen the evidence base supporting the delivery of nursing curricula. It was suggested that adopting *"what's popular, what people think is a good idea" (HEI Aus)* or perpetrating *"this is what we have been doing for ages" (HEI UK)* could influence curricula development. One academic had *"seen curriculum change over the years, goes round and around"* and questioned if there would ever be *"an ideal model" (HEI UK).*

Another driver was considered to be the increasing market driven business model within higher education, noting *"it's a business model nowadays" (HEI UK).* Coupled with changes in healthcare such as *"hospitals without walls"* and increasingly the *"private sector coming in so much more" (HEI UK),* these changes were considered to have potential to further impact placement availability. At site 1, one proposal was for a 'broker', someone to source new placements and set up the required legal and working agreements. Other staff suggested greater clinician presence within the administration of placements again to help identify 'new', 'novel' or 'emergent' placements.

A place for simulation

A major factor considered in moving forward was the role of simulation based teaching and learning, an increasingly embedded strategy within health profession education. The view in this study was that simulation and clinical experiences needed to complement each other to benefit the student. As this academic stated:

> *"Let's recognise it* [simulation] *for the positives benefits that it has but let's also recognise the positive benefit of clinical" (HEI Aus).*

The findings cautioned against the direct replacement of clinical time with simulated learning experiences. This academic's view argued in support of the unique role clinical experiences contribute particularly in communication, empathy and compassion:

> *"I hope to god that we never in Australia see Sim time being a pragmatic way of dealing with the clinical placement shortage. I think that's an absolute dangerous route to go and people arguing around 'they do it for pilots and so on', well pilots fly a plane. You cannot do it with humans…..nurses deal with humans who are unexpected creatures and I think that communication and increasingly more and more the empathy, compassion stuff is huge and we need to foster that and you kind of don't get that from anything but clinical" (HEI Aus).*

That simulation could not "*compensate for a real life practice placement" (HEI UK)* was echoed at site 2. Another academic agreed stating that *"clinical exposure should never ever be replaced by anything else",* as the clinical component was for many believed to be "*where you prove yourself as a nurse" (HEI Aus).*

Some staff believed that simulation had an "*artificialness*" as healthcare was constantly "*changing and morphing*" and even when embedded in a "*complex scenario*" this could not address the "*complexities on the complexities!" (HEI Aus).* The challenge in replicating real patients and recreating the intangible aspects of practice were central to the perceived limitations of simulation, as this academic's observation exemplifies:

> *"When you are in a skills lab everyone is getting on fine but then you are in the personal dynamics of a ward team hmm you're thrown into the clinical mix and balancing and managing resources and people being admitted and discharged and some of the patients being pretty unpleasant people. Throwing all those different kinds of things, and staffing levels, you can never get that in skills lab" (HEI UK).*

For simulation to substitute for clinical comments were that there would need to be complete wards and the full range of "*other things that impact on your day"* ranging from when a *"...patient needs to go to x-ray*" to the "*anger that will be expressed when surgery is cancelled for the 4th time hmm." (HEI Aus).*

However, staff considered how to most effectively harness the potential of simulation. Given the variable nature of the clinical environment, the consistency or quality of learning could potentially be superior via simulation. One academic recalled a student's account of a placement experience where they had been restricted to a non-participatory role and questioned "*if maybe we could do something better in a simulation environment with somethings"* (HEI Aus). Controlled simulation experiences could provide every student with an equitable foundation prior to practice. This UK academic rationalised a plan to build student capacity prior to their first substantive clinical placement using a combined simulation and clinical strategy:

> *"I wouldn't let them near a clinical area for a year. I would put much more emphasis on SIM practice in a much more strategic fashion.....I would like a much more integrated approach to SIM learning so that by the end of year - 'I know how to do various things, I've practiced on my colleagues I've practice on the dummies'. 'I've had visits to clinical areas during that year just the odd day perhaps as a taster, and I am looking forward to year 2 where I am actually going to get out there and start practicing' " (HEI UK).*

Other staff added further benefits, such as how "*high end quality Sim can be an exceptional preparation for practice*" for example with technical skills, "*moving on from the orange, please inject your orange!"* (HEI UK). The ability in simulation to "*go back and do it again*" was an asset and if a "*situation didn't go too well*" students had the opportunity to rehearse their practice. Finally, simulation was also seen as a valuable tool in managing students at risk of failing as staff could "*deconstruct their practice have a better look at it*" and "revisit things in safety" (HEI UK).

Placement diversification within the education model

When asked to dream forward, staff considered how changes in the broader healthcare sphere may influence clinical education. Clinical education had historically centred on placements in acute care settings however, some diversification towards community and primary care areas was occurring. Primary care and community based services had seen less exposure to students, yet, these were considered to be areas of rapid growth and diversification. Hence, staff were able to identify untapped resources for placements, such as Children's Centres for child field experiences at Site 2, which offered a multi-professional environment with a range of services. Yet, a perceived challenge in small or novel placements was ensuring adequate student supervision if the service, for example, had few RNs or was managed by social services.

Similarly, another academic considered some of the specialist areas of practice that in the past had taken few, if any, students. Given the changing health profile of the population and chronic illnesses emerging as a major healthcare burden for the future, exposing students to less traditional areas was seen as beneficial to both the student and the service:

> *"…until really fairly recently students were frowned upon…..'what are they going to learn here', 'they'll get in the way'……we cannot recruit in specialist services so you have to expose nurses to – 'grow your own type of thing'. That's where you'll get your nurses from. We still have those challenges but more and more I see locally students going into* [specialist] *areas and they love it" (HEI UK).*

For small or highly specialised areas, implementing the Hub and Spoke model was advantageous. The area could be used as a hub placement with the student able to 'spoke out' to get wider experience, or if the area was not suited to being a hub, students could still be exposed to it as a 'spoke'. Spoke placements were also suggested as a means of providing diversification into more creative placements, including making greater use of nurses in specialist or advanced roles. This would expose and orientate students to the 'bigger' picture aspects of nursing and healthcare care, as illustrated in this observation:

> *"…the Director of Nursing, shadowing some of those people….. almost aspirational…..even something like shadowing people who are bed managers*…..[students] *they want to make a difference, they want to care for people.....but you can only do the hands on stuff if there are a lot of other people doing the hands off stuff letting you do that!" (HEI UK).*

As placements that were less 'traditional' hosted fewer students on a regular basis, some staff felt those placements needed to develop their receptiveness to students. In turn, students also needed guidance and appropriate supervision to be able to identify the various learning opportunities available. For example, if a student placed too much emphasis on 'doing' nursing, they may perceive that a placement in outpatients, for example, could limit skill development. However, the following example, using medication administration as an example, demonstrated how learning opportunities could be applied:

> *"So you might think in an outpatient area they don't give the medication but they may talk about medications but pre-registration nurses get obsessed with the doing, the act of medicines administration but they don't see the wider context of it.....by sending them to other areas like rheumatoid clinics..... they do injections there, eye clinics they do drops, so they are taught different things, if they go to the diabetic clinic they are taught about administration of insulin..." (HEI UK).*

Staff were cognisant that the demand for clinical placements risked placing students in more unusual or obscure placements. For example, the viability of a placement in an X-ray department, whilst certainly valuable to visit, may be considered limited as a long-term placement. Therefore maximising the learning opportunities within such placements needed careful consideration. Finally at site 1, several staff suggested developing university-led clinics, offering clinician-led services to the public would be a useful way of developing placements and for students to gain experience under supervision. However, the numerous challenges in achieving this were acknowledged.

6.3: Theme Two: Being a nurse

This theme is philosophical in orientation and considers aspects of becoming and being a nurse. The first sub-theme, examines shifts in nursing image and identity and draws on the outward image of the nurse and the portrayal of the nurse or nursing in society. The second sub-theme concerns the transition from student to employee. Despite the differences in the two programs the point of transition between university and commencing employment was raised at both sites as an area to target when dreaming *what could be*. The sense that there was something different about the final year or final semester of study and ideas to restructure the transition to

registered nurse were proposed. The final sub theme highlights staff views of the value of real life clinical experiences and in particular the emotional element in being a nurse which students need to navigate.

6.3.1: Shifts in nurses' image and identity

Historically, the 'nurse' and 'nursing' had an identity which was tangible, even symbolic. The uniform for example, was representative of the profession, perhaps especially so for the public, as this academic observed:

> *"…students are often quite blasé.....but I say to them you do not know how you are going to feel when you are there and all eyes are on you, you're the nurse, you're in uniform, you are in the position of authority, power, you might just be a student but to the relatives and the patients you are a nurse" (HEI UK).*

Uniform could convey power and traditionally had been used as a visible indicator of hierarchy. Even as a student "*you moved through the hierarchy very quick"* and gained *an "extra stripe on your hat or shoulders and each time you had more power..." (HEI UK).* This aspect of student identity was felt to be less overt today as outwardly *"there is no real differentiation between someone who is 2 weeks away from registration as someone who has just started" (HEI UK).*

Students entering nursing may have a predetermined image of what nursing is and where it takes place. This academic considered the enduring popular culture image of the nurse and the centrality of acute care anticipated by many students as 'nursing':

> *"…but generally a lot of students want to be on a ward, they want to experience that acute nursing experience" (HEI UK).*

At site 2, the first placement was targeted at giving students an experience aligned to this typical expectation of where nursing 'takes place'. Although nursing occurs in a multitude of settings, the acute care ward embodied 'nursing' for many people:

> *"All first year, first placements are ward placements.....It's another thing from student satisfaction* [survey], *it gives them the best idea of what they are going into, rather than something like district nursing or health visiting which isn't really.....And it's a good thing they can decide if course is right for them" (HEI UK).*

Embarking on each clinical experience could be overwhelming for students who may not know what to expect. This was considered especially so for beginning students if they have never been exposed to a clinical setting and if not managed well the student could question their choice of a nursing career:

> *"It can be quite daunting and you do get the students who come back from clinical and it's, 'I didn't expect that'. So that's like when they go 'OK this is maybe not the career choice for me', from that first clinical..." (HEI Aus).*

Placements with lots of perceived 'technical' tasks matched some students' expectations of nursing rather than placements with seemingly less overt nursing skills. Students therefore needed guidance to identify a range of learning opportunities and understand the reality of the "*softer skill set*" of the nurse as described here:

> *"…the times my students say 'I've been doing bed baths for 3 weeks when can I start doing something nursing?' They're focusing on injections, or medications or things like that rather than basic nursing care. I think that comes down to the point that students focus on skills..... and sometimes they don't focus on the soft skills that you have as part of your job and although that is inherent as part and parcel of your role they don't think that that's really important.....We need to.....tell them that this is what you are learning – these skills 'cause a lot of them say 'I've not learnt anything on this placement' and they've learnt so much and you have to go over it and emphasise this is what you have done here" (HEI UK).*

Addressing the narrow view students may hold about the nurse and nursing, academics described how they translated the complexities of different areas of nursing. This academic considered children's nursing and the breadth and richness of experience, beyond being *"in there doing things"* necessary to develop to be a *"complete children's nurse"*:

> *"Students come into children's nursing with the idea that they're going to look after really sick children all of the time in ICU. It's very interesting. We work really hard to show them that children's nursing is much bigger than that, it's more diverse…….. actually going out with a health visitor and talking to a mum and a newly born child is really, really valuable and what a privilege..." (HEI UK).*

Addressing misconceptions and apprehensions in order to understand an area of nursing, was seen to be important as even senior students could experience a renewed anxiety and need orientation when encountering 'unfamiliar' clinical areas such as palliative care or mental health services, as described here:

> *"With that comes a lot of misconceptions that mental health people are aggressive, that they can be violent, that they are unpredictable, you know. So we try to dispel a lot of that because the facts are that mental health patients are no more violent than anybody else out there in society.....so I think some of their reservations and anxieties are around that everybody out there that has mental illness is the Hitchcock Psycho patient, they don't have a very good concept what's a psychopath and what's a mental illness, they're all psychopaths…." (HEI Aus).*

It was considered that universities could have a more effective role in promoting a contemporary image of nursing. Considering how *"the narrative is framed to the students" (HEI UK)* it was questioned as to whether *"we do that well even before they come into uni in terms of expectation setting" (HEI Aus),* as this academic reflected:

> *"[students] going out with the community mental health team – 'well all we do is speak with people', well what do you think mental health nursing is about! So many problems we encounter, I think, is because the University*.....[promotes] *'this is what it going to be like'. It's not like that and we all know it's not like that..." (HEI UK).*

This extended to perceptions on the mismatch in the current expectations of what a new graduate nurse should be. This academic described the concept:

> *"There is still this different understanding of the expectations of the new graduate nurse. That we prepare them for being 'this' and the service sector expect 'this' and they can be quite distinct, distinctly different. So I think the strategy is for making sure both sectors, the education and the service sector, if you like to use the words, are creating the new graduate nurse that will fit the bill" (HEI Aus)*

Several staff had views that in order to educate nurses that *"fit the bill"* the programs to prepare novice nurses needed to refocus and streamline and develop a *"generic nurse"* as a solid foundation to future practice:

> *"We have lost what a nurse is so for me...it's about refocusing if we were looking at the course and the standards, 'cause we are having a change in the UK at some point the standards will change. But I think we need to look at the generic nurse, I think we have tried to go too wide" (HEI UK).*

Factors influencing this were the vast array of specialities that come under the broad banner of nursing and the diverse ever expanding areas and settings within which nurses function. This raised questions about what an undergraduate program comprises, to produce a 'beginning' practitioner who can subsequently develop into the *"many variants of the nurse".* As this academic contemplated:

> *".....we give them a bit of everything. I know there is a lot of work going on around this, if we are focussing on too much, at the detriment of focusing on the core. The core of what is essential and basic care, how to recognise deviations from normal. So there is something for me about the student actually becoming a nurse in the generic sense of the word before the specialism the student 'wants to be an accident and emergency nurse'.....actually it's not about that" (HEI UK).*

Another aspect to this was the emergence of assistant practitioners, healthcare assistants and a spectrum of other roles. In addition there were *"so many titles: advanced nurse, specialist nurse"* (HEI UK) that *"what a nurse is"* could seem *"lost"* and the education system considered to have *"tried to go too wide"* (HEI UK). Other staff viewed the preparatory nursing program as the 'start of the journey':

> *"…and I say I was a student nurse, I was sitting where you are and I had the same nerves and anxieties, you are not going to be an expert it's a long journey you're on, and this short 3 year journey is part of it. And all of a sudden it will be over and you will be a registered nurse" (HEI UK).*

Consequently, nursing programs were seen as needing to reframe and produce a novice nurse within the greater context of an ongoing professional education journey. At the start of that journey was the transition of the student to the newly registered nurse.

6.3.2: Transitioning from student to employee

At both sites, staff identified the point of transition as students completed their program of study and commenced employment as a registered nurse as pivotal. Consequently, staff spoke of wanting "*much more of a run-in to becoming a registered nurse" (HEI UK),* an effective means to bridge across the two spheres:

> *"...you put a different uniform on and suddenly people are treating you differently and expecting more. And that happens overnight..." (HEI UK).*

Staff observed the transition from student to nurse had always had an element of *"culture shock"* which may be greater now that in the past. The students in this study were supernumerary, which was seen by some staff as influencing the development of independence necessary in the transition from learner to worker in the busy modern healthcare workplace:

> *"The NHS is fast paced, there are sick people and you know you're going to have to hit the ground running in January and you really need to go in with sort of open eyes" (HEI UK).*

Successful transition could occur via a quality preceptorship period although this was not always guaranteed. At site 1, many, but not all, newly registered nurses commenced their nursing careers via a 'Transition to Professional Practice' (TPP) program or 'new-grad' program. This participant conceptualised this 'new grad' program as a fourth year of learning, consolidating the BN program:

> *"…your nursing degree is preparing you for your grad program and I think the grad program is the fourth year of your degree. You're not actually really a*

> *full nurse and even after that year you won't feel it but I feel like the things I learnt in my grad year you could never learn at a university" (HEI Aus).*

There were concerns at site 1 that not all students get a TPP, as availability did not necessarily align to the number of nursing graduates. Accessing a TPP in New South Wales is a competitive process prompting the view "*that would be the dream; everyone gets a grad program in a hospital learning the skills you cannot learn any other way" (HEI Aus).* There was a sense that in transition "*you don't know what you don't know",* including skills such as prioritising *"and so the only way you learn it is to do it" (HEI Aus).* Hence, longer nursing programs were suggested such as "*let's make it a 4 year degree and the last year a full clinical" (HEI Aus).* Another academic suggested an additional consolidation semester or a fourth consolidation year for *"on the job training"* which would also serve as mechanism to connect graduates with the *"lifelong learning idea. So it's not degree, done!!" (HEI Aus).*

Other points raised at Site 1, were options to modify clinical across the years so that clinical time "*starts small and gets bigger"* with the theory-practice ratios shifting to become "*75:25; 50:50; and 25:75".* Staff at site 2 also wanted to ensure sufficient practice in year 3 to ensure students were sufficiently prepared to meet the requirements both for a degree and professional registration. The following comment considered the potential lack of opportunity to put the theoretical elements of the program that are taught in the final semester or even final weeks of the program into practice:

> *"They all come to the end of year three and they are looking at managing change and they do that theoretically but they don't get a chance to put that into practice.....the opportunities to try to implement some small change in practice would be really valuable I think, good for the student but also the clinical areas getting a new idea" (HEI UK).*

At site 1, a transition period in the final year of study could provide *"reality training"* in preparation for the real world students would enter on registration. Several aspects of this were noted, starting with this comment on ensuring preparedness for shift work:

> *"…this…..business of oh 'you know we can't put them evenings and weekends' and then the first thing they do as a new grad is they have no idea of the level of fatigue of shift work and stuff …and we should have been preparing them for that in third year" (HEI Aus).*

Further at site 1, the common practice of 'off placement' debriefing as part of the clinical facilitation model of supervision, was felt by this academic to detract from the essential socialisation processes as part of transition:

> *"I say to my third years and facilitators unless something has happened I do not want them to be debriefed cause if you are going to be part of the ward and connectedness….who gets dragged off every afternoon…, it's about sameness, we want to be like them, want to go to afternoon tea with them, they want to learn the nursing talk.... socialisation so much part of what we are wanting...." (HEI Aus).*

A transition also occurred at the beginning of the nursing program with the student's first clinical experience. Some participants noted this too was a point of difference as students' transition 'into' the program. The first placement was an opportunity to consider how best to orientate students to understanding basic building blocks of healthcare as considered here:

> *"I feel there is a real importance in certainly first year, consolidating some of that ward routine to understand how a shift works, being ward based and maybe they could be introduced to more of that 'inter, trans, intra disciplinary' but really understanding the large team that operates for…persons' health care...." (HEI Aus).*

Hence, introducing the student to the healthcare world via their first placement would assist them being able to conceptualise the context within which they would develop and practice as a novice nurse. Projected through to the conclusion of their program, the 'student' nurse needed to be transitioned in a way that promoted their connection to their new role as a beginning registered 'nurse'.

6.3.3: Feeling like a nurse

Clinical placements, though taking differing forms (as described in Chapter Five), were embedded in the nursing program at both sites. This theme presents staff perceptions on the unique contribution real world experiences had in the development of novice professional. In establishing the importance of the essence of the 'nurse' and 'nursing' this academic reflected:

> *"...people come into nursing because they believe they can do it and they don't just think they can do it because they can functionally perform-- it's usually something about themselves that drives them. And often if you say what is special about that nurse? They* [patients] *won't say what's special about that nurse is the best ever dressing off them, or they asked me every single question on the assessment sheet, or they were on time. They'll tell you things about that person that's often related to their values or their virtue ethics, their person.....but the therapeutic use of self is something that is absolutely pivotal to clinical outcomes and the therapeutic relationship and you need to be there with the patient to be able to do that. So that's probably one of the most important things yeah" (HEI UK).*

The findings were suggestive that nurse education would be "*profoundly worse off, for not having clinical experiences"* with one academic adding, they "*couldn't imagine a high quality new grad" (HEI Aus)* without real world experiences. These experiences also ensured students developed *"passions for different areas"* and gained "*a whole different world view of what nursing is about" (HEI Aus).*

An essential component in experiencing reality was the range of emotions and feelings students' experienced, as one academic observed students *"also get to be terrified..." (HEI Aus).* The start of each new placement could elicit a strong emotional response, as this academic recalled the apprehension and anxiety students face starting a placement:

> *"…you walk in and the first thing that happens is your heart is going 50 to the dozen, 'will people like me, will I fit in, have I enough knowledge, do I know what I am doing?' It's visceral, they have abdo pain, they're sweating..." (HEI Aus).*

The power of the clinical experience was further captured in academics' accounts of their own personal experiences. One recalled their first placement and the *"feeling of being totally out of control, not knowing what's going on and not knowing what to expect"* and the associated impact stating it was *"frightening and you never forget that" (HEI UK).* Another reflected *"I had English as first language, was a reasonably kind of resilience person and I found it horrendous"*, stressing the importance of remembering how *"confronting clinical is…for students" (HEI Aus).* Particularly confronting could be elements such as "*death and dying"* and dealing with situations where *"there's not a nice ending" (HEI Aus).* Whether it was being terrified, anxious or experiencing joy and satisfaction, the feelings evoked in real world experiences were considered difficult to replicate in other ways:

> *"…and I don't think they have yet got a dummy to hug you, so that real strong emotional component I don't think can be mirrored" (HEI UK).*

Another aspect of reality was that students on placement were *"doing it for real"* and therefore *"the consequences are real" (HEI UK).* This 'cause and effect', meant students had *"to be on the ball every interaction....and every contact" (HEI UK)* and process the associated complex feelings that arose. Recreating such feelings in the classroom or via simulation was considered to be limited, as highlighted in this observation:

> *"What you cannot guarantee is what it feels like if you let someone down, I don't think they can guarantee what it looks like looking into a families eyes when something's…you know, when you go home and you feel 'I messed up or I did really well'. It's the realness and the rawness and the consequences of it and the rewards that you get. You might only get to do a 10th of what*

> *you wanted to do but the drawing the child has given you to take home is something you will never let go of. Yeah I think those things are different and special" (HEI UK).*

Authentic interaction with people and the clinical environment was considered an important requirement for students to develop confidence and assuredness to 'be a nurse'. Some staff referred to this as *"professional intuition"* the sense of 'knowing' that cannot be *"taught ….in university"* but something that had *"to happen out there in practice" (HEI UK).* Reflecting on their own development of intuition, this academic felt student engagement with the complex multifaceted environment of healthcare was irreplaceable in their development as a nurse:

> *"I can't teach students that. They have to go out there and they have to feel what it's like to be with that patient and they have to sit in that situation and sometimes feel uncomfortable and you cannot simulate that…..[you can] plant the seed but until they have sat with that nurse or been in that situation, you cannot bottle that stuff, you just have to go out there and wait for it to find you" (HEI UK).*

Another academic reflected on themselves as a nurse stated, *"I feel like, I as a human, walk into a room as a nurse"* and proceeded to describe the complex nature of nursing work as seen through the eyes of a student buddied with the registered nurse:

> *"…the student sees* [the RN] *put a blood pressure cuff on a patient but you are doing 30 things all at the same time and you don't get to learn that until you actually are the one doing, who has to do those 30 things in the one minute and it will all be in your head….. because it's so hard to teach 'cause you can't verbalise all the things you are doing at that one time, especially in those critical situations…" (HEI Aus).*

Real world experiences were considered to be where 'it' could all come together, where the student connected skills, theory, practice and sensed themselves becoming a nurse. To conclude this theme is this facilitator's comment on the satisfaction of witnessing everything falling into place:

> *"It's so good to watch someone* [student] *come into a debrief and launch into a huge story about an amazing thing they did that day and just know that they loved it and they….had one of those moments when it was 'yep this is it, this is what I am going to do' - It's great, love it!!" (HEI Aus).*

Finally, in the UK several participants referred to the *"public pressure, being put on nursing",* a reminder that drivers could be both *"public and political" (HEI UK)* and meeting this wealth of competing need would continue to challenge for undergraduate nurse clinical education into the future

6.4: Chapter summary

The preparation of the novice nurse is inextricably linked to, and influenced by, wider forces, including, professional and educational evolution, societal changes and political positioning layered onto existing logistical challenges. Despite all of this, in this final findings chapter a passion was evident for the nurse and for nursing and preserving the integrity in nurturing the next generation. The sense that the healthcare and education sectors need to continue and further develop how they collaborate was a common dream moving forwards as was the need for the profession to lead the way.

CHAPTER SEVEN: DISCUSSION

'Sometimes it's the journey that teaches you a lot about your destination'.

Drake[16]

7.1: Introduction

The primary aim of this study was to identify the conditions conducive to meaningful clinical learning experiences, facilitated by a collective inquiry into what participants perceived worked well in the clinical component of two differing preparatory nurse education programs. A secondary aim was to envision what could be, amidst the challenges facing nurse education globally, to inform the future provision of innovative practice oriented components of nurse education. In addition, a revitalised exploration of the contribution clinical learning experiences make to nurse preparation was sought.

At the core of clinical education models, regardless of the intricacies, is the student as beginning practitioner, an experienced supervising nurse and learning opportunities, co-located within a clinical setting. This clinical setting is simultaneously a patient care environment, work environment, research environment and learning environment, generating a situated learning experience. Yet, there are no guarantees that a meaningful, positive or quality experience will result. This study examined the dynamic, complex learning environment and the network of forces within (Dunn & Hansford 1997). In this chapter, the findings will be explored and interpreted, to develop insightful understanding of the factors that contribute to meaningful clinical learning experiences and how their contribution to the student's transition to becoming a nurse, can be enhanced and evolved.

To situate the discussion, this chapter adopts and adapts Bronfenbrenner's Ecological Systems Theory of Development (1977) to conceptualise the key findings from this study within and across the individual, organisational and wider professional levels influencing clinical education and the extensive interconnections within. The term *ecological*, as Capra and Gunter (1995, p.3) proposed, is used in an expansive form, in order to see *'the world as an integrated whole rather than a dissociated collection of parts'* and highlight the relative interdependence of the phenomena under study.

[16] High School Graduation Speech Oct 2012. Canadian recording artist, songwriter, and actor Aubrey Drake Graham (known simply as Drake).

The discussion of the findings is bounded by the time and location, educational model and governance frameworks at the two case study sites. Existing literature is incorporated to support the discussion and the insider–outsider stance of the researcher further informs the interpretation of the findings. The recommendations arising from this study, are presented in Chapter Eight, the Conclusion.

7.2: Revisiting the purpose and process of this research

The study's primary aim was to capture the *best of what is* in two differing approaches to the delivery of clinical education, including student supervision and identify the key elements for success. Building from this was to then imagine *what could be,* using this vision to inform the design of innovative, meaningful clinical learning experiences for undergraduate nursing students. Participants were final year nursing students and higher education staff, both academic and professional staff involved in the preparatory nursing programs of one English and one Australian university. The study objectives were to:

1. Deepen the understanding of the characteristics of undergraduate nurse clinical education models that are conducive to promoting meaningful experiences for students and identify the individual and organisational factors that support and influence them.
2. Appreciatively explore the perceptions of students, academics and professional staff as to what works well and how or why it works well, with particular reference to:
    a) the organisation and implementation of the clinical placement model;
    b) meeting the individualised learning needs of nursing students;
    c) students' progression to becoming nurses;
    d) the provision of student supervision;
    e) structure and duration of clinical placements.
3. Generate insights into potential innovations, new designs or opportunities for future undergraduate nurse clinical education, shifting from the location or team bound 'placement' to student clinical learning 'experiences', with reference to:
    a) strategies to best prepare students and supervisors for engagement in clinical experiences;
    b) diversifying and maximising clinical learning opportunities.

Addressing these aims and objectives guided the study reported in this thesis and inform the following discussion.

7.3: Bronfenbrenner's Ecological Systems Theory of Human Development

The findings, presented in Chapters Four, Five and Six, identify that the provision of meaningful clinical learning experiences is dependent on a myriad of influences spanning individual, organisational and wider professional levels. The student's actual clinical experience is the proverbial *tip of the iceberg*, with layers of contextualised complexity above and below the surface which support and contribute to each individual experience. Bronfenbrenner's Ecological Systems Theory of Human Development (1977) provides a novel basis to illustrate the interface of the complex systems of healthcare and higher education, with the emergent, but less considered complex world of the contemporary nursing student, which collectively hold the individual experience at its core. The interplay between various agents at individual, organisational and professional levels can be envisaged to better appreciate the interconnectivity and sources of influence in clinical education. As Bronfenbrenner's systems theory incorporates the effect of change over time, two time-based continuums in this study are brought to the fore. The first is the continual progression-regression dynamics in the evolution of nurse education and the second, the students' transition to become a nurse.

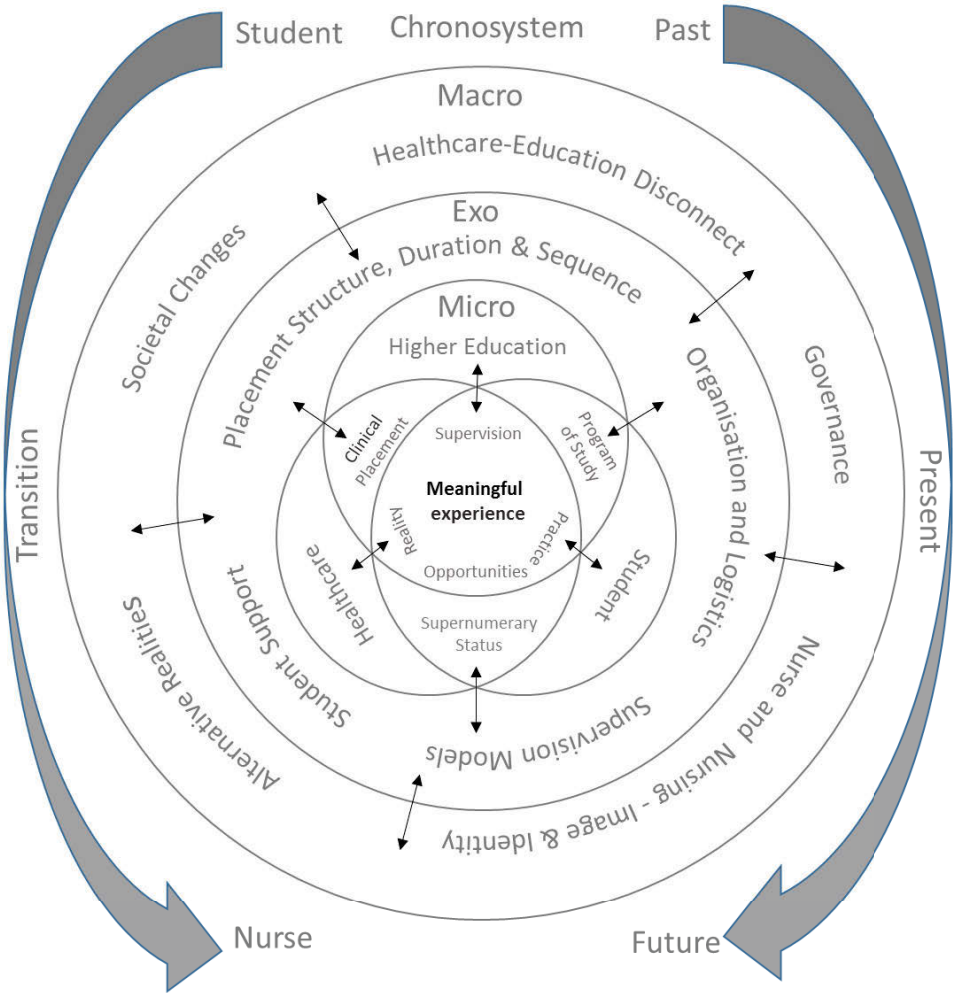
Bronfenbrenner's Ecological Systems Theory of Human Development (Bronfenbrenner 1977) centres on the developing human being within a changing social environment, and the various interpersonal and wider interactions within. The theory has five linked systems of complex interaction that affect and are affected by an individual's development (Snyder 2013). These linked systems are visualised diagrammatically as a nested arrangement, with the layers, as originally described by Bronfenbrenner (1977, p. 514-515) comprising:

- Microsystem: relations between a developing person and their immediate settings (e.g. home, school) and contacts (e.g. parent, teacher, employee);
- Mesosystem: bi-directional interactions between various immediate settings, an interaction of microsystems;
- Exosystem: an extension of the mesosystem, formal and informal social structures that influence the immediate settings;
- Macrosystem: the wider context within which the structures, settings and contacts exist, includes social, economic, political and educational systems;
- Chronosystem: long and short term time scales, influencing both individual and systemic actions. This fifth system represents the influence of time and was a later refinement to the theory (Bronfenbrenner 1986).

Adapting Bronfenbrenner's Systems Theory, the study's findings are represented as an ecological system in Figure 7.1. This representation places the individual student experience at

the centre, amidst 3 interconnected micro systems, the students' personal system, the higher education system and the healthcare system

Figure 7.1: Ecological Systems Theory Model of Undergraduate Nurse Clinical Education (adapted from Bronfenbrenner 1977, 1986).



Visualising undergraduate nurse clinical education as a complex system based on Bronfenbrenner's Systems Theory, facilitates the recognition of the context, interconnectedness and resultant complexity of the multiple influences on the student learning experience

7.4: A systems view of clinical education

The two cases in this study, at Site 1 and Site 2, provided a snapshot in time of the respective approaches to the provision of clinical learning experiences and their contextual variables. Each

approach comprises several complex systems and multiple agents nested in the wider context of the nursing profession and various factors historical, societal or political, that had, do and will continue to influence their complexity over time. Modelling as an ecological system demonstrates that given the high level of interconnection, shifts in any component of the system or agents within can have a ripple effect elsewhere in the connected layers of the system, with the potential to affect students' clinical learning experiences.

The academic and professional staff participants, in this study, incorporated recollections of their experiences over time, generating a context within which to evaluate the *here and now*. This generated a compare and contrast element in the narratives of staff debating the merits of the current approaches to clinical education. Prominent was the impact many had witnessed of the fragmentation of nurse education, with a perceived disconnect between higher education and healthcare evident in the findings, something that has been debated in the literature (O'Driscoll, Allen & Smith 2010). The perceived disconnect is represented in the physical shift of students being located within the university, the philosophical shift to degree level qualification and shift of primary responsibility of nurse education to the higher education sector. This disconnect or perceived disconnect needs to be set against the backdrop of previous approaches of nurse education, which emphasised training rather than education.

In this study, it was evident that there were elements within each case study that worked well with a sense of a shared role between the healthcare and the higher education sectors. Evidence of the connections between healthcare and higher education were evident at both sites, yet appeared more developed at Site 2 in the current study's findings. This connection was illustrated in the notable support for the 50:50 split of total program hours between theory and practice, such that half of all the students' education time is clinically based. In addition, the sign-off mentors' role engages the healthcare sector considerably in the responsibility for student progression.

The re-development of relationships, as described by Robinson et al. (2012), were seen as the *glue* that holds the system together. However, facilitators of these relationships, such as the sustained viability and support for initiatives such as Practice Education Facilitators (PEF's), have been considered areas for concern (Scott et al. 2017).

The contemporary nursing student

The two cases in this study illustrate how the evolution of nurse education has impacted today's nursing student, including the changing status of the student with the switch to supernumerary

status. The impact of students' personal circumstances on their interaction with healthcare and higher education was particularly evident at Site 1, with evolving changes emerging at Site 2.

The status of the contemporary nursing student was demonstrated in answers to questions on the desired duration of clinical time, with students revealing pragmatic reasons for their preferences. This study identified that despite a majority of students, particularly at site 1, wanting more clinical time (Chapter Five), their engagement in paid work and other lifestyle related issues, such as managing family or childcare commitments, were clearly seen as determining how much clinical time was desirable. Studies have shown that students are spending an increased amount of time (Hall 2010) or a significant amount of time (Robotham 2012) in paid work. The major reasons in this study were predominantly financial and maintaining their standard of living, as was also identified in studies by Hall (2010) and Robotham (2012). The average age of students participating in this study (27.8 years), is indicative of a shift to an older and more diverse student population with increased potential for students to have families, mortgages or other support needs.

Aligning the twenty-four hour cycle of healthcare and nursing with the personal system or life of the full or part time student may challenge students' ability or willingness to work unsociable hours. Yet, many academic staff felt exposing students to the reality of the full spectrum of nursing shifts early in the program was necessary, to inform their appreciation of the professional reality of nursing and whether nursing was suitable for them. Notable in the findings was the predominance of site 1 students only undertaking morning and afternoon shifts at site 1 contrasted with a full spectrum of shifts at site 2. Gaining exposure to all shifts whilst under supervision was considered to be a strength in preparation for future practice. Staff and student participants indicated that access to night shift and weekend work was an asset to prepare new graduate nurses for practice in the real world. However, it could be debated, that with the shift to emphasise student status, any requirement to do rotating shifts for their entire program may bring new challenges.

Historically, the apprentice nurse was salaried or received a bursary, may have lived in subsidised accommodation and was typically placed at local hospitals. With the shift to university status, students can incur significant costs in the form of fees, living expenses and transport costs to access placements. An Australian Commonwealth supported student studying nursing full-time has a yearly fee contribution (as of 2015) between AUD $0–$6152, though the Good Universities Guide (2017) indicated most universities charge the maximum. According to the official government site for international students, Study in Australia (2017), international

students pay fees of $15,000 to $33,000, per annum for an undergraduate bachelor degree. In England, students had received a means tested bursary by way of financial support, however, the bursary was phased out on 1st August 2017 (Ford 2017). As a result, reports claim that there has been a 23% drop in applications in England for university nursing and midwifery courses (Adams 2017). This example is illustrative of the interconnectedness across the layers of influence reinforcing the need to view the system as a whole. If a decline in recruitment to nursing programs occurs, this impacts supply of new nurses to address the predicted shortfalls in staffing. Nursing students enrolling from 2017 onwards use the system of tuition fees and maintenance loans used by students studying non-health related degrees. One outcome of this financial shift may be that the long, shift-based placements of English programs become less desirable or sustainable.

Practice Curricula

Billett (2016, p. 128) defines the practice curricula as the 'types and sequencing of experiences' required to develop healthcare knowledge and this study specifically sought views, particularly from the student perspective on the respective practice curricula. In particular, views on the structure and duration of the clinical component were sought given this is a long debated issue within nurse education programs (Mannix et al. 2006; Levett-Jones et al. 2008). Some features, such as the field structure at site 2 have emerged from nurse education reforms in the 1980s (RCN 2007). However, at both sites some aspects of clinical placements were considered influenced by governing bodies, custom, pragmatics and demand rather than a strong evidence base. For example, as Ralph et al. (2017) notes, the rationale for the 800 hours minimum in Australia, is not 'articulated' by either the ANMAC or Nursing and Midwifery Board of Australia (ANMAC 2012). Similarly, no evidence base is readily evident in the EU directive governing the UK's 2300 required hours (EU2005/36/EC). Yet, these macro-level influences drive placement structure. Ralph et al. (2017, p. 122) proposes that the design of nursing curricula based on hours can become a process of 'settling for less', giving the example of with the establishment of a minimum requirement of 800-hour clinical experience for accreditation in NSW.

Whether a field-based versus a generic nursing program was most desirable at undergraduate level was inconclusive in this study. There was support for a dedicated children's nursing program, whereas the merits of specific preparation for areas such as adult and mental health were more equitably debated. This consideration may be indicative of societal changes and the need to respond to changing health patterns, co-morbidities and growing burden of chronic disease (Glasper 2015) and expected growth in community and public health roles for nurses

(Willis 2012). Staff participants drew from experience and acknowledged the continual contextual changes over time and the need to consider the nurses' role in future health systems, as was raised in a think tank on the future of Canadian undergraduate nursing education (MacMillan 2013). MacMillan (2013) presented arguments for a strong generalist foundation as a basis for later nursing specialisation, supported by some participants in this study. As healthcare continues to evolve, new demarcations for the nursing workforce may be warranted.

Duration of clinical experiences.

The duration of placements and overall clinical time was notably different in the two cases in the study, generating debate on the relative advantages and disadvantages. It was evident from the present study that there needs to be sufficient time for the distinct 'patterns' of engagement, clearly evident in both case studies, to occur. The long placements at site two, supported students' ability to settle into a placement and develop a feeling of *belongingness* which Levett-Jones and Lathlean (2008) found to be a necessary precursor to learning. In comparison, the typical placement duration at Site 1 was two weeks. The students and facilitators at site 1 who had experienced both 2 and 4 week placements noted that in the longer placements, students were more able to effectively engage with the team and participate with greater learning perceived to occur.

The considerably longer placements at site 2 did raise concerns, as there was a perceived risk for students to become part of the numbers, or a pair of hands. The pedagogical philosophy of long 3 month placements has been questioned elsewhere (Saarikoski, Marrow & Abreu 2007) as to whether this could regress to a more apprenticeship-orientated rather than student-centred model of learning. Also noted in the findings regarding long placements, if the setting was not receptive to students and the area was one students had little interest in, a placement of any duration could be perceived as too long. Long placements were also suggested to generate a *disconnect* from University for students. A bridging role bringing a visible academic presence to students on placement (Site 2) had met with considerable success

Nurses and Nursing - Image and identity

Perspectives on the image and identity of the nurse and nursing pervaded all layers of the findings in this study. As Hallam (2001) states, nurses and nursing are complex constructs and image and identity may be conceptualised via professional or personal perspectives and through popular imagery such as in the media. The image of the nurse has been described as too narrow, often portrayed based on the image of the hospital, bedside nurse (Stephenson 2017). The collective, extensive experience amongst the academic staff described the challenge in

reconciling their nursing identity given their potentially multi-faceted roles as researcher, academic, and clinician. However, Hoeve, Janson and Roodbol (2014) describe how nursing fails to more forcibly align these professional capabilities with their public image, contributing to a 'fuzzy' public image of nursing. The sense emerged that many students enter nursing with a popularist or traditional, often acute care image of the nurse and nursing. This image may represent a mismatch between the nurse a student perceives they will become and the nurse a changing profession and society will require. Some staff promoted the concept of creating a foundational practitioner with the capacity and skills to evolve with changing needs.

If nurse education is in a vortex of change, addressing the short term effects, needs to be balanced with the direction required in the longer term. Relatively short curriculum cycles ensure response and renewal on a regular basis but this may fail to drive long term governance and leadership. The findings at both sites did not overly raise centralised leadership as something that worked well, though leadership, governance and direction were clearly evident in elements of the whole system. Connections across healthcare and higher education seemed stronger at site 2 with more reported collaboration. In the Australian context, El Haddad, Moxham and Broadbent (2016) have called for stronger shared collaboration and responsibility, not only between universities and healthcare providers, but with regulatory bodies at the governance level to ensure the systems delivers practice ready nurses on registration.

One of the drivers for reform in nursing and in nurse education is the aging nursing workforce and anticipated increased demand for nurses in the future. Buchan, Duffield and Jordan (2015) refer to the option to increase the recruitment base as a traditional policy response to nurse shortages. However, increasing intakes into nursing programs may further compound the demands on clinical placements such that this affects other parts of the systems as a whole.

7.5: Organisational level connection and collaboration

The mesosystem in Bronfenbrenner's Ecological Systems Theory represents the bi-directional interactions which manifested as effective collaboration between the health sector and education providers. These connections were indicative of the highly interconnected and entangled interactions within, between and across the various subsystems that comprised the roles, processes and technologies that supported clinical placement experiences.

With changes to nurse education and a perceived lack of leadership for learning in the clinical setting, Allen (2010, p. 209) considers that students may experience 'the uncoupling of their learning in clinical practice from their learning of theory', with potential for fragmentation and

disruption for a 'whole' student approach. In the current study, connection at the meso and into the exo levels strove to bridge this perceived *uncoupling,* with multi-directional connections, straddling the complex systems of education and healthcare, and cross-connecting the micro (student) and macro layers as depicted in Figure 7.1. The findings revealed the wealth of commitment, energy, resource and creativity that went into making clinical placements work, and work well. Robinson et al. (2012) revealed the 'hinterland' required to drive mentorship, and the current study exposed the 'behind the scenes' complexity in clinical placement provision. A network of adaptive mechanisms and roles were evident in the study findings at both sites, though these emerged as more overt at site 2, where the healthcare and university relationship was strongly connected, with students aligned to a particular NHS Trust(s).

The potential for power imbalances between patient-focused healthcare and student-focused education appeared alleviated when a shared vision of the next generation of nurses promoted productive partnerships. Collaborative quality improvement via feedback systems was more evident in the findings at Site 2 and described very much as a shared venture. The establishment of roles such as Practice Education Facilitators (PEF's) in healthcare and academic education liaison roles, were representative of the commitment to re-connect at the interface. PEF's are established as a valued support for both students and mentors across the UK (Carlisle et al. 2009, Scott et al. 2017). An academic-based liaison role at Site 2 had developed in response to local feedback to support students on placement and particular address first placement culture shock. At Site 1, the centralised ClinConnect system had fostered productive relationships through its shared use between health providers and education institutions.

For all the positive connection, there can be tensions at the interface of complex systems. In many Australian university-healthcare partnerships, the model of student supervision is Clinical Facilitation (Needham, McMurray & Shaban 2016). At Site 1, this facilitation model can appear to be overly formulaic when coupled with a data-based system like ClinConnect, contributing to some of the phenomena in the findings. The clinical facilitation model is based on a 1:8 ratio driving a one size fits all approach, which can be challenging if, for example, 8 student places are not available at a given facility. As clinical facilitation is not traditionally provided at night, this may also contribute to students at site 1, primarily doing AM and PM shifts.

7.6: Meaningful clinical experiences – the interface of microsystems

Within the findings, learning via engagement in authentic clinical practice was highly valued. However, simply being in the clinical setting, with proximity to practice did not mean that learning would emerge, as also noted by Jackson and Watson (2011) and Mennin (2010).

Students valued engaging with effective, well-functioning teams, in a conducive sociocultural environment that embraced them as a junior colleague. Within this environment, effective supervisors nurtured the next generation of nurses, giving students the freedom to learn within a supportive environment.

7.6.1: The Heartland of the Experience - Meaningful Engagement with Practice

Despite notable differences in the clinical education models within the two cases, the conditions that worked well for meaningful experiences to occur were very similar and followed distinct patterns, culminating in students' integration into authentic practice. Influenced by placement duration with sufficient time these essential inherent patterns of engagement were accommodated and included:

- The development of the student-supervisor relationship;
- Being made to feel welcome and part of the team;
- Facilitated access and connection to learning opportunities;
- Recursive practice to develop confidence.

The student: supervisor relationship

The student-supervisor relationship was seen as *"absolutely key"* and a major factor in meaningful clinical experiences. When describing their best experiences, students repeatedly reported that "*who they were working with"*, was most significant, with the relationships formed considered more important than the nature of the clinical placement. This reflects findings of previous studies, which identified the importance of student-supervisor relationships as a crucial determinant in students' clinical experiences (Antohe et al. 2016; Gurkova et al. 2016; Papastavrou et al. 2010; Saarikoski, Leino-Kilpi & Warne 2002; Saarikoski et al. 2008; Sandvik et al. 2015; Sundler et al. 2014). As Saarikoski et al.'s (2007, p. 414) study of eight nursing schools concluded, the 'mentorship relationship and a satisfied student go hand in hand'. Studies using Chan's (2002) validated Clinical Learning Environment Inventory, also showed that *personalisation*, the opportunity for students to engage directly with their clinical 'guide', is integral for student satisfaction (Ip & Chan 2005; Brown et al. 2011).

The findings from this study indicate that, regardless of the student supervision model, the educator, mentor, clinical facilitator or RN buddy, working alongside the student, has a key influence on outcome. However, the varied context and approaches to student supervision makes direct comparison amongst supervision models challenging. In this study, the use of an appreciatively orientated inquiry helped to reveal that despite the differences, the supervision model mattered less than the attributes of the individual 'agent' of direct supervision. Walker

et al (2013) also concluded that the quality of the support on offer, regardless of model, mattered most to students. This too, is highlighted in a comment made to the Willis Commission inquiry:

> 'The placement is as good as the mentor you have and as good as the student you have and the interaction between the mentor and the student' (Willis 2012, p.33/34).

The positive attributes of effective supervisors identified in this study closely align to those already established in the literature. Courtney-Pratt et al. (2011) and Myall, Levett-Jones and Lathlean (2008) found mutual respect and understanding contribute to positive relationships and promote student engagement, encouraging students to question, participate and seek advice. Effective relationships were described as 'supportive' or 'friendly' and facilitated by supervisors who were 'enthusiastic or comfortable in the role', 'welcoming', 'confident', and 'committed' to students' (Courtney-Pratt et al. 2011 & Myall; Levett-Jones & Lathlean 2008). These personal attributes create an inclusive culture with what Mennin (2010, p.25) refers to as a suspension of 'power differences' between the teacher and student generating a 'reciprocal relationship-centred approach' from which both parties benefit and learn.

However, given the chance way student and supervisor come together, positive interactions may not be achieved. Factors influencing this included the expectation at site 2 that RN's take on a mentoring role as a requirement for career progression and at site 1 whether there was sufficient preparation and support for the clinical facilitation model. When students perceive that nurses are reluctant to supervise them or feel unwelcome the formation of relationships and learning are inhibited (Andrews et al. 2005; Williamson et al. 2011). Staff perspectives in the findings added that the workplace could be a potentially toxic environment for student nurses. As one study, by Birks et al. (2017) has reported that 50.1% of Australian and 35.5% of UK students' placement experiences, had encountered bullying, primarily by other nurses.

Being made to feel welcome and part of the team

This study reinforced the understanding that for meaningful experiences, students need to feel welcome, that they belong, are respected and appreciated and are part of, and can contribute to, the healthcare team. Similar findings are established in the literature (Birks et al. 2017; Bradbury-Jones, Sambrook & Irvine 2007; Chesser-Smyth 2005; Edgecombe & Bowden 2009; Levett-Jones et al. 2007; Papp, Markkanen & von Bonsdorff 2003). When identifying the best or most successful placements in this study, students and staff, at both sites, described the existence of a welcoming, inclusive culture for learners, aligned to the concept of 'belongingness' as identified by Levett-Jones et al. (2007). There was a risk expressed, especially

at Site 1, that students can be seen as visitors in the clinical setting, with their presence tolerated rather than embraced, a further manifestation of the perceived shift of responsibility for nurse education. As Bradbury-Jones, Sambrook and Irvine (2011) also identified, when nurses see the learner as integral to their work activity and value the student as a future team member and respect their contributions, meaningful experiences can occur.

This notion of embracing and "*nurturing"* the next generation of nurses, to grow and develop, was seen as most effective when an active interest in the leadership or responsibility for education, was adopted by an individual nurse, educator, manager or the wider nursing team. However, in this study, a strong sense of where the responsibility for the leadership regarding clinical learning experiences was centred did not emerge. The perceived disconnect of healthcare and education, resulting in what Allen, Smith and O'Driscoll (2011) describe as a disintegrated context for learning is considered influential. Allen, Smith and Lorentzon (2008) state that historically, leadership for learning was held by ward managers, though with shifting work patterns, responsibility had been delegated to those in practice teaching roles such as mentors or practice educators.

Connection with learning opportunities

The shift away from an apprenticeship model to the establishment of the nursing student as a learner with supernumerary status, lay the foundation for students to learn through supervised participatory practice rather than being part of the workforce (Allan, Smith & O'Driscoll 2011; Mannix et al. 2006; McGowan & McCormack 2003). Participatory practice, requires interpretation of supernumerary status, and in this study students' engagement with learning was dependant on the appropriate opportunities being available and the facilitation of active engagement with practice. What worked well for students was connection with an enthusiastic 'guide' (RN, mentor or facilitator) who invited, allowed and supported students to participate in authentic care. In addition, students reported not wanting to feel they were being used as a *"pair of hands"* or unpaid help, a risk for students that has been reported elsewhere (Bradbury-Jones, Sambrook & Irvine 2011; Murray & Williamson 2009).

The optimal balance between *work* and *learning*, was seen as a complex phenomenon. As reported in the findings, a 'great' student could be one that made the beds and did the vital signs, contributing to the 'work'. This could be perceived as potentially at the cost of a more enriching learning opportunity, one which could take the student further in their learning and development. Hence, the feasibility of the clinical education model at sites 1 or 2 could be jeopardised if students were expected to *work*, rather than learn via supernumerary

participation. However, in all scenarios, students need to be able to understand the learning that can be occurring and how this informs their development. Challenges with interpretation of supernumerary status have been reported elsewhere. For example Allen, Smith and O'Driscoll (2011) in studying experiences of supernumerary status in the UK, found that in practice, supernumerary students are still expected to provide labour and students, therefore, needed to have the skills and ability to negotiate their supernumerary status to access learning opportunities (Allen & Smith 2009; Brammer 2008).

In this current study, caution was levelled in balancing doing tasks with other aspects of learning. Several references were made to students needing to have greater flexibility to follow their objectives or the patient journey to enhance the breadth of their learning experience. When students are allocated to an RN and patients to provide holistic care, the focus may become more work rather than learning oriented, with students potentially missing out on enriching opportunities. Ironside, McNelis and Ebright et al. (2014) found that despite calls for radical transformation in nurse education, the clinical learning experience in three US universities was too focused on patient care tasks rather than on developing more complex aspects of contemporary nursing practice.

Some student narratives described placements that had the qualities of being inclusive and pervasively positive which benefitted the students, staff and patients. The descriptions fit with the concept of Communities of Practice (CoP), where professionals both learn from, and contribute to, their community, supporting student participation (Lave and Wenger 1991). Lave and Wenger (1991) asserted that Communities of Practice support learning through partaking in practice (situated learning) and legitimate peripheral participation encouraging socialisation and increased engagement with the work of a group.

Recursive practice to develop confidence

Evident in the student participants' responses was the reality of 'doing nursing', evoking the conception of nursing as a practice-based profession with emphasis on procedural knowledge, which Billett (2011) describes as the 'know how'. It was suggestive that clinical skills, especially motor or technical skills, may act as a currency, helping students to 'fit in', be accepted and able to contribute. When talking about what worked well, students referred frequently to the repetitive practice of skills and opportunities to build on from existing skills. Students need to be able to integrate knowledge and experiences to develop new understanding and meaning, and specifically stated, in the current study, ability to develop their confidence.

The importance of confidence was also noted by Holland et al. (2010), who identified that a lack of confidence at the point of transition from student to RN contributed to perceptions that newly qualified nurses lacked clinical skills and were not fit for practice. A sound basis and development of confidence in core skills and ability to continue to learn is important if students are to be prepared to enter diverse clinical settings at registration. This current study questioned the need to better understand which skills could be developed via simulation-based teaching methods including virtual or augmented reality, prior to clinical placements. Utilising simulation could support the adoption of deliberate practice with skill mastery for motor skills, where the more students engage in practice the better they will become, as suggested by Gonzalez and Kardong-Edgren (2017).

Students also indicated in this study that they needed to be *allowed* to participate in practice within their level or scope of practice. When transformational learning experiences were described these were linked to examples of mentors or facilitators supporting the student with sufficient challenge and responsibility encouraging the student to not only act but think like a nurse. This follows Vygotsky's Zone of Proximal Development (ZPD) concept, which is where 'good learning' is proposed to occur (Verenikina 2010). The ZPD is defined as:

> 'the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers' (Vygotsky, 1978, p.86)

With guidance and support, learners are encouraged just beyond their existing level of development or competence (hence proximal) to actually build on their existing skills or abilities (Sanders & Welk 2005). To achieve this, Levyhk (2008, p.83) describes the need for a safe and 'emotionally positive collaboration' to develop between teacher and student which supports the learners' development to a higher level. As Levett-Jones and Lathlean (2009a) also promote, students must have a secure basis within the clinical setting to feel motivated intellectually and emotional to further continue their development.

In this study, some of the strategies associated with the Zone of Proximal Development, which staff and students reported worked well included provision of feedback, role models and the scaffolding of experiences across the program of study (Sanders & Welk 2005). Students described examples of scaffolding, such as taking a pulse in a variety of settings. Mennin (2010, p. 24) identifies that when learning opportunities are scaffolded across the clinical curriculum, the 'end of one event becomes the beginning of the next', known as recursion. Hence, the student does not simply repeat the same task but can build from existing ability, such that

interactions in the richness of the clinical setting can create a *'bottom up'* process of learning which Mennin (2010) refers to as self-organisation. In addition, the sequence of learning opportunities has been identified as contributing to student development, such that previous learning experiences can be recognised and skill acquisition can build progressively (Williamson et al. 2011).

The mediators of the Zone of Proximal Development in this study were the RN's, mentors and clinical facilitators who worked alongside the student. Comment was made that whoever is supervising the student needs sufficient confidence in their own skills and ability to effectively support student learning and development. Experienced nurses adopted the role of expert guides and were able to judge how much responsibility the student could take. Jansson and Ene's (2016) observational study of a preceptorship model found this ability to understand the students' needs, along with continuity of supervision were important for student progression.

In this study, students described their *best* clinical experiences as having sufficient challenge and increasing responsibility for transformative learning or development to occur. Although change and a level of unpredictability (Jess, Atencio & Thorburn 2011) are considered crucial factors in learning, a challenge for learning during clinical experiences is managing too much or indeed too little challenge or responsibility. Optimising the zone of proximal development could be derailed if the sequencing of experiences does not follow the student level or, for example, if year 1 and 2 experiences did not sufficiently prepare students for their final year. Learning develops from the ability to take what you know and apply it in differing and often unpredictable situations of practice. Students have a growing tool kit that has to be applied in various settings and although there is order, no two days ever look the same.

7.6.2: The power and paradox of unpredictable reality

In this study, a philosophical debate developed as to whether real world clinical experiences remain warranted, given that the clinical component of nurse education is increasingly challenging to support (Smith, Corso & Cobb 2010; Salamonson et al. 2015) and educational strategies, such as simulation, are much championed alternatives (Hayden et al. 2014; Curl et al. 2016). The findings generated strong views, across both sites, that in-situ clinical learning experiences offered a unique and non-replicable reality, which contribute uniquely to the dynamic state of 'becoming' a nurse. However, this reality was inherently unpredictable due to the complexity and diversity in healthcare, with the potential to exert influence on a student's lived reality of each clinical learning experience. Reality emerged as both a major element of

what worked well, yet posed its own challenge by generating a sense of randomness, as one participant remarked placements change *"day to day, not even week to week"*.

Throughout the findings was a strong sense that *"you cannot teach reality"*, and participant responses conjured up the rich layers and interactions comprising healthcare, considered to only occur "*out there*". Exposure to real world practice socialised students not only to nursing, but also the wider culture within which nursing occurs. This exposure contributes to students' development of canonical knowledge, which encompasses an individual's understanding of society's expectation of the occupation of nursing and what those practising nursing would be expected to know (Billett and Henderson 2011). Reality emerged as also contributing to students' engagement with genuine real world nursing practice, appreciation of the dynamic, ever changing context of the clinical setting and development of dispositional knowledge for practice. The acquisition of dispositional knowledge (Billett and Henderson 2011) refers to the values and intent that guide individual actions, which in this study, included feelings of responsibility, consequence, pressure, stress, excitement, satisfaction, even exhaustion. Participants felt these emotive aspects of nursing could not be substituted and learning to become a nurse had to include exposure to authentic nursing practice.

In addition, authentic nursing practice was seen as facilitating students' development of, what one academic referred to as the *"softer skills"* of nursing. This awareness of the emotional intelligence required for nursing, encompassed empathy, kindness, communication and therapeutic use of self. Exposure to real world experiences was considered to offer the best opportunity to craft these skills, as they were considered less tangible concepts to teach. As Bronfenbrenner has asserted, in human development there is a need to go beyond intellectual growth, emphasising the ethical and emotional aspects of being human (Wertsch 2005). The development of ethical awareness and ethical capacity, has been identified as an important part of the process of students becoming nurses (Sandvik, Eriksson & Hilli et al. 2015).

Despite the consensus that real world experiences were crucial to students' development as a nurse, reality also contributed to a level of unpredictability. With this came the potential for non-linearity, highlighting the varied trajectory each student can have and the role this variation may have in the fit for practice debate.

7.6.3: The non-linear journey to becoming a nurse

The theoretical and embedded clinical practice components of the undergraduate nursing program are mapped out in linear plans over 3 years, at sites 1 and 2 in this study, with 10 or 6

placements respectively. The clinical practice learning objectives are scaffolded to support the attainment of the competencies determined by the relevant governing body and the pre-requisite practice hours are accumulated over the three year degree program. Despite this proposed linear trajectory, the study findings highlighted the potential for non-linearity in the sequencing of placements such that learning opportunities may arise in a serendipitous way. As each student is also unique in terms of their pre-existing knowledge, skills and life experience, the non-linearity of their trajectory will be further impacted by sensitivity to these individual starting points, also referred to in complex systems as *'initial conditions'* (Rickles, Hawe & Sheill 2007, p. 934).

Linearity occurs when a cause and effect relationship exists between two entities, and a change in one entity causes a predictable and directly proportional change in the other (Kannampallil et al. 2011). In contrast, complex systems are inherently non-linear and the *'stimulus and response are unequal'* (Clancy et al. 2008, p. 252), and contributes to the systems unpredictability. Large student numbers, multiple mentors or clinical facilitators and varied placement destinations meant that students could progress at different rates with a randomness to their accumulative experience over time. The number of agents in the form of nurses, doctors, patients, supervisors and others each student encounters all further add to the complexity. Students' non-linear trajectories towards becoming a nurse, may, in part contribute to the perceived lack of clinical skills and not be sufficiently considered as part of students preparedness to practice on registration (Holland et al. 2010)

Consequently, what worked well was when learning opportunities aligned and matched to the students' level of ability and were appropriately challenging, factors also identified by Papp et al. (2003). Staff in the current study wanted to see greater equity of opportunity to generate a more linear trajectory for students across their program of study. The UK's implementation of the sign-off mentor (SOM) (NMC 2010) had promoted a whole of program review of each student to ensure proficiency to enter the register. Integral to the success of SOM is the heightened collaboration between Trust staff including mentors, practice education facilitators and the higher education institute as well as the preparation of mentors and students for the SOM role (Barker et al. 2011).

As one agent amongst many in the clinical placement experience, each students' own preparedness, their attitude to learning and their readiness for engagement with practice was perceived to influence how nursing staff engage with students, both in the present and in future encounters. The need for students to be aware of their own "*agency*", something Billet (2014)

refers to as *'personal epistemology',* emerged in both the student and staff voice within the findings. The student's personal epistemology manifests as a unique starting point in terms of motivation to engage in their own learning, their preparation for clinical experiences and for some students an insightful awareness of the impact of their presence in the clinical environment.

Both intrinsic and extrinsic factors influencing motivation were evident in the findings. Intrinsic factors included a lack of interest or perceived relevance in a field or area of nursing. Extrinsic factors related to family and paid work commitments which have also been identified by Edgecombe and Bowden's (2009), along with assignment load as having potential to impact negatively on student engagement with their clinical learning. As schemes to widen participation in higher education gain momentum (Young 2016), the entry level ability, needs of students and range of pre-existing knowledge and skills has the potential to diversify further, as forecast by Benner (1984). Consequently, the individuals' need to build and transform knowledge from their own world view may also influence motivation (Benner 1984). Whatever the underlying contributing factors, any lack of enthusiasm or motivation to learn can compromise effective student supervision and learning (Courtney-Pratt et al. 2012).

Addressing the non-linearity in exposure to learning opportunities at site 2, the Hub and Spoke model was considered to offer a valuable mechanism to align learning needs at an individual and program level. With relatively long, yet limited number of placements, the Hub and Spoke approach was credited with optimising students' ability to direct and access appropriate learning opportunities. This endorses the findings of Thomas and Westwood (2016) who reported the Hub and Spoke model promoted access to a diversity of knowledge and experience, resulting in more in-depth learning. Thomas and Westwood's (2016) qualitative evaluation of the Hub and Spoke model at one university found the spokes facilitated students' ability to follow the patient journey and acquire new skills to bring back and consolidate their practice in the hub. However, mentors need to be oriented to and support the students' learning needs within this hub and spoke model, for example, ensuring mentors in spoke locations who may infrequently host students, remain up to date with learning objectives and assessment procedures.

The Hub and Spoke model offered a means to support students' need to belong and be part of the 'team'. Roxburgh, Conlon and Banks (2012) and Millar, Conlon and McGirr (2017) found the Hub and Spoke model to be student-centred, supporting continuity in learning and enabling students to view patient care in a holistic way. This includes opportunities for students to follow patients or families over periods of time and within and across healthcare settings (Benner et al.

2010). The Hub and Spoke model is also accredited by Roxburgh (2014) with enhancing a sense of belongingness due to an extended attachment to a hub.

A final factor in the non-linear journey identified in this current study, and linked to a whole of system phenomena, relates to paid employment. More than half of the UK students and a majority of Australian students reported working in a healthcare related role in addition to their studies. This aligns to a characteristic of complex systems, referred to as a 'fuzzy boundary' (Mennin 2010; Plsek & Greenhalgh 2001), and questions what aspects of student development are attributed to their paid work, as for example an AIN, versus the contribution of learning via their clinical placements. Hasson et al. (2013) found that healthcare related paid work benefited students' confidence, skills and clinical exposure but role confusion could make it difficult to switch mind-set between healthcare assistant and the student as learner. There is scope to further explore the impact this has on student development. For example, the effect of paid work on student satisfaction was evident in a study by Salamonson et al. (2015) which found students employed in the healthcare care sector less satisfied with their clinical experiences than students in non-related work or not in work.

7.7: The nursing education continuum - dreaming forward (chronosystem)

In this study, emergent in the staff narratives in particular, was the ongoing continuum within nurse education and how the past and the present, influence the future. Anticipating the role of nursing and nurses in the future, in response to changes in society and healthcare, has generated debate within the profession on the need for transformation in nurse preparatory education programs (Benner et al. 2010; Willis 2012). However, in the present study many students reported positive placement experiences, when it all came together and worked well, indicative that reforms need to be mindful of the attributes and dynamics in existing systems, as Mannix et al. (2006) also cautioned over a decade ago.

In his 2005 book 'Making Human Beings Human', Bronfenbrenner suggests that industrialised societies have altered environmental conditions such that the 'process of making human beings human is in jeopardy' (Bronfenbrenner 2005, p.xxvii). Applied to nurse education, the early chapters in this thesis explored a range of factors that are purported to be jeopardising the sustained provision of clinical education. Hence, nurses and nursing, need to be mindful that the complexity, context, and interconnected relationships that can nurture the next generation of

nurses are not unduly jeopardised in the drive for reform. All nurses are or can become active contributors to the professional development of the next custodians of the nursing profession.

Consequently, when considering possible future reform for undergraduate clinical education, the proposals presented were not overly radical but indicative of creative thinking to enhance and enrich the learning experience.

7.7.1: What could be - creating the future next generation nurses

When exploring how to enhance clinical learning experiences, consideration was given to greater flexibility, tailoring of the supervisory approach to match student need or level and systems to better augment the transition from student to registered nurse. The notion that *one size does not fit all* clearly emerged in the findings suggestive of a need for greater creativity in approaches to the provision of clinical learning experiences, as the following examples illustrate.

Greater Flexibility

Greater flexibility was considered a means to develop a more student-centred stance and promote students' ability to follow not only the required objectives, but also their personal interests. One suggestion was for short *taster placements* which supported the student to gain insight/experience across differing areas of nursing practice, in addition to more substantive placements to refine core skills. Consequently, some participants wanted to see flexibility to support students to move across team or location-based boundaries to promote access to appropriate learning opportunities. This was seen as a means to ensure sufficient consistency in the skill or experiences students were exposed balanced with the ability to tailor the experience to the students' needs. Greater flexibility has been proposed by Benner at al. (2010) to find alternate ways for students to progress and develop the abilities and independence to be truly work ready.

As alluded to earlier, the Hub and Spoke model at site 2 was an asset in this regard, as also reported by Roxburgh et al. (2012). The Spokes gave students the desired fluidity so that they were able to seek out appropriate learning opportunities away from the Hub to complement their development. In addition, a cluster of experiences could be 'packaged' as described by one academic, such that a placement on a surgical ward may include spokes to a pre-admissions clinic or operating theatres. The flexibility of Hub and Spoke also allows for student free breaks for high demand Hub areas whilst exposing students to Spoke areas, which may not be traditionally associated with hosting placements.

Student supervision

A manifestation of the non-linearity identified in this study centred on how students' supervisory needs could change across their three year program. Hence, when considering the enhancement of student supervision, the merits of a mixed model for supervision were considered advantageous. Academics and clinical facilitators, particularly at Site 1, advocated for the need for more flexible models of supervision, especially with reference to the current, predominant clinical facilitation model. The findings of this study indicate that various supervision models are effective. However, depending on the type of setting or stage of student development, a particular model may offer specific advantages to students as they transition through their program of study.

First year students may benefit from 'doing nursing' under close supervision with a dedicated 'clinical teacher' to develop a core skill set and confidence, as in the clinical facilitation model (Chesser-Smyth 2005). In contrast, at the point of transition to registered nurse, supervision models such as preceptorship, as observed at site 2 in this study, where students follow an RN's shift patterns, promoted independence and assimilation to the profession (Henderson, Twentyman & Heel 2006). Despite the differences in the student supervision model at sites 1 and 2, there was agreement in further scope to value and invest in those taking on the 'supervisory' role.

Student to registered nurse transition

An area seen as pivotal for students was the transition from student to registered nurse which this study identified as an area for further development. Participant suggestions ranged from creating a 4 year degree program, with the 4th year focused on transition, to superior preceptorship programs for new graduates to effectively support them as an RN. Enhanced support at the time of transition to RN assists new nurses to develop confidence, develop skills applicable to area of practice and embrace the concepts of capability (Fraser & Greenhalgh 2001, of lifelong learning (Holland et al. 2010). A further mechanism proposed to support transition is to align students to their destination facility and future colleagues. In an Australian study which compared student preparedness for practice based on differing clinical teaching models, Patterson, Boyd and Mnatzaganian (2017) found that a University Fellowship Program (UFP), where students have a majority placements at a single facility, enhanced their work readiness. A feature of the model was in-house student supervision by facility staff, which reflects the mentorship model at site 2 and the use of Facility Appointed Base facilitators (FAB), a model of in-house facilitation, was emergent at Site 1.

Transitioning to professional reality and addressing the move from student world to work world and being more embedded in healthcare was seen as an area for creative thinking and innovation. For example, having more of the students' clinical hours towards the completion of the program with models of supervision in the final year that promoted the students being able to buddy with a RN and follow their roster, were suggested. Several staff proposed four year degrees with the 4th year centred on transition, and a gateway to professional lifelong learning. This is not a new concept as Duchscher (2009) refers to 'transition shock' and designing clinical experiences that prepare students for the challenging dynamic context of professional nursing practice. Thomas, Bertram and Allan (2012), support the idea of a bridging experience that reflects real practice of the RN to increase realistic understanding of the RN role before graduation. This realism was better supported at site 2, for students within the preceptorship model of supervision, however, as Gardiner and Sheen (2016) note, the new graduate nurse also needs to feel welcomed and supported by their more senior colleagues.

Bridging the academic clinician divide

An effect of the shift in nurse education to the higher education sector, is the transition from clinician to academic, referred to by Murray et al. (2014, p. 391) as an 'identity shift'; this would seem to be an important concept, although review of the literature reveals limited exploration. Hence, when considering what could be, emergent in the findings was a desire to bridge the apparent academic-clinician divide, a manifestation of the theory-practice gap in the context of this research. Some academics indicated a desire to maintain or develop roles that more effectively spanned the education, clinical and/or research paradigms. The rationales for this included maintaining credibility as a clinician, career satisfaction and ability to enrich contemporary educational endeavours. Elliot and Wall (2008) suggested possible barriers to academics retaining or developing clinical engagement were the lack of visibility in the academic's workload and limited career benefit. Several staff did add that the medical profession seemed more able to achieve a blended identity in a more effective and sustainable way than nursing had. In part, the concept of clinical schools located within the health facility, were considered as a factor in this. Lee and Metcalf (2009) found a nursing focused clinical school established as a university and healthcare care partnership benefit both clinicians and academics. The clinical school fostered clinical-academic collaboration, supported a positive research environment and led to changes in care delivery.

Numbers: a threat to creativity

Although the purpose of this study was to identify what worked well, barriers and challenges inevitably emerged as part of the dialogue. Of note, at both sites, the large student cohort numbers were considered to threaten the ability to effectively deliver current placement models and were a threat to quality overall. The challenge to find sufficient placements has been noted (Smith, Corso & Cobb et al. 2010), as has the need to substitute a general setting, when a desired speciality placement such as mental health, cannot be sourced (Happell & Platania-Phung 2012). However, the commissioning process at site 2 allowed for more precise predictions for student numbers, which aligned to anticipated future demand at a local level via Health Education England. Active collaborations between healthcare and education providers have been demonstrated to build capacity as a shared objective, such as reported by Barnett et al. (2008).

Teaching reality? - Harnessing simulation-based teaching and learning strategies

Simulation-based teaching and learning strategies are a range of techniques that 'create a situation or environment to allow persons to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions' (Lopreiato et al. 2016, p. 33). Well established in the healthcare education portfolio, simulation-based learning is considered a valuable adjunct to other teaching and learning strategies across the health care professional education platform. Studies are seeking to determine how simulation can substitute or replace clinical experiences (Hayden et al. 2015; Watson et al. 2012). In these studies, the merits of simulation-based education were raised and its role as an adjunct to clinical experiences is advocated. However, simulation as a pragmatic solution to placement shortages was considered short-sighted. Rather, simulation needs to be harnessed to ensure students were fully prepared for clinical practice in order to maximise this limited resource. However, as Bradshaw and Merriman (2008) critique, participation in skills laboratories, although an expected component of contemporary undergraduate nurse education, typically has no agreed standards and the effectiveness and impact on student preparation may vary.

7.8: Transformative learning – making student nurses, nurses

Ultimately, engagement with practice culminated in students commenting on their personal journey of transformation and 'becoming' a nurse and accounts of their 'a-ha' moments featured in the findings. The ultimate connection between the student, their guide and learning opportunities resulted in students identifying as nurses. The transformation was the taking on

their own nursing identity; this transformation was perceived as being part of a continuum of becoming, with staff in the study speaking of the lifelong and fluid, multiple nurse identities that exist. However, the system nurses are in is also in a perpetual state of becoming, not being (Jordon 2010).

A key element of this transformational learning was the students' philosophical shift in values and beliefs and the deep emotional connection described by participants in the study. As one participant expressed *"I, as a human, walk into the room as a nurse"* representative of a change in self-perception and as Simsek (2012) states a way of operating in the world. What worked well were experiences where students could identify as the nurse they were becoming and part of this was their emotional development. Leonards (2017) argues that healthcare is an emotionally challenging environment and students can benefit from nurses' and educators' ability to reflect on and role model their own responses to the emotional aspects of nurses' work.

The layers of complexity at the individual, organisation and professional levels behind this transformation were undoubtable evident in this study. This transformation required a complex web of factors, within and across the multiple layers. Part of the complexity is the unpredictability, a placement setting that may be remarkable one week may be mediocre the next. What works for one student and their 'a-ha' moment will not be what works for another, without necessarily tangible reasons. Similarly, the supervision model that works for ward A may not work for Clinic B, even in the same facility. Hence, the provision of clinical learning experiences is complex, rather than complicated, as strategies may not be transferable within or across settings (Snyder 2013).

Patient or service user involvement is increasingly advocated in the planning and development of nurse education programs (Lathlean et al. 2006; NMC 2010; Rush 2008; Willis 2012). However, despite the obvious centrality of the 'patient' to the students' clinical learning, reference to the patients' contribution to meaningful learning opportunities was somewhat limited in the findings of this study. The emphasis in the role of reality and engagement with authentic care delivery certainly implied patient engagement as important for students but few direct references were made. Within the clinical setting, healthcare consumers have been reported as willing to be active participants in student learning, sharing their stories and cooperating with student-delivered care (Stockhausen 2009). Stockhausen (2009) suggested effective communication between all parties and supportive inclusion of the student promoted active engagement in learning. Further, Gidman (2013) and Stockhausen (2005) found service users

are an important source of knowledge and highlight the powerful and emotive value students place on the opportunity to listen to patient stories and understand the patient perspective during clinical experiences.

7.9: Chapter summary

The findings from this study establish that meaningful clinical experiences are complex phenomena and more than the sum of their parts. Bringing together a student and an expert guide within a clinical setting are central to a meaningful learning experience. However, layers of elements within several interconnected complex systems need to align for a student to have a meaningful developmental experience that contributes to their journey in becoming a nurse.

There is a wealth of research on clinical learning experiences with some specific components clearly elucidated with a high level of understanding of their role in the student experience. However, to truly innovate requires appreciation of the whole complex system as a connected entity within and across multiple layers. In addition, in this study, the role of time both at the micro student level and the macro societal and professional level was evident. Appreciating the trajectory of nurse education as continuum, allow us to examine the effect of historical changes such as the impact of the disconnect between health and education means that instead of negotiating one complex adaptive system, the student experience lies at the intersection of several systems and represents the increasingly complex world of the university nursing student.

The significance of the findings in this study are that each meaningful clinical learning experience is more than the sum of its parts and there is a serendipity as to how those parts come together and play out. Therefore, given the call for innovation and reform, those charged with the governance of nurse education, at all levels, need to be cognisant of context, complexity and interconnectedness of all the agents and parts of the system that is the provision of clinical learning experiences. Second, the interconnectedness of multiple factors and agents make the provision of clinical learning experiences sensitive to the 'butterfly effect' (Begun et al. 2003); a concept that even small changes in one part of the system, can have varying effects elsewhere in the overall system. Finally, students need to be embraced and nurtured as the next generation of nurses within an individual, organisational and professional continuum of learning and development within the enigma that is *nursing*.

CHAPTER EIGHT: CONCLUSION

'The nature of the whole is always different from the sum of its parts'

Fritjof Capra[17]

8.1: Introduction

The aim of this research was to better understand what makes a meaningful clinical learning experience and how this contributes to the student's development as a nurse. Embedded in a qualitative paradigm, case study methodology was adopted to examine two differing approaches to clinical education provision and facilitate debate on the merits of the two systems. Incorporating principles of appreciative inquiry to focus on the positive, rather than targeting challenges, was an intentional mechanism to promote energised and renewed thinking in this area. This novel approach supported learning from the past and identifying the best of the present, to inform the future design of clinical learning experiences for students. While some of the findings further endorse existing knowledge, the contribution of this research is the holistic view bringing together a systems-based modelling of undergraduate nurse clinical education to highlight the context and continuums that inform the complexity of clinical education. Theoretical and practically orientated recommendations are generated for the provision of meaningful undergraduate nurse clinical learning experiences to meet future need.

To appreciate meaningful clinical learning experiences requires the identification of essential elements and understanding of the context, interconnection and complexity of these elements within the system as a whole. This study demonstrated that enhanced understanding of fundamental elements, patterns and the dynamic, non-linear nature of clinical education can guide reform. As healthcare is projected to rapidly evolve in the near future, *a one size fits all* approach will not address the needs of nursing students, the nursing profession and healthcare provision. Innovation and change in preparatory nurse clinical education needs to be informed and driven by the context and complexity within which it is, and will be embedded.

In concluding this thesis, this chapter revisits the purpose and processes undertaken in this study. The implications of this research are presented as recommendations for consideration by those charged and engaged with curricula development and clinical placement provision. The strengths and limitations of the methodological stance and design taken in this study are also examined. As Donnelly and Wiechula (2012) propose, case study afforded an appropriate

[17] Fritjof Capra, 1996, The Web of Life: A New Scientific Understanding of Living Systems

foundation to explore the complex, varied and situated phenomenon of clinical education provision. Yet, as all research has limitations, the constraint and challenges encountered in the study are reviewed, and this critique may offer considerations or direction for future exploration in this field.

8.2: Revisiting the process of this research

The first chapter introduced the changing and diverse contexts within which nursing and undergraduate nurse clinical education, take place. Despite numerous approaches to nurse education, reports suggest there are mutual challenges and common societal and professional drivers that will impact the future provision of nurse clinical education. This background set the context and warrant for this study, from which the research aims emerged.

Chapter Two determined if a preferred model for clinical education existed, however, no one single approach or model of clinical education emerged as wholly preferable to another. The literature review identified common core elements necessary to support students' positive experiences regardless of clinical education or supervision model. These elements centred on interpersonal relationships, with success also dependent on the reliability, viability and sustainability of each approach to clinical education.

The third chapter detailed the frameworks, research design and methods utilised in the implementation of this study. The findings from the study were presented in Chapters Four, Five and Six, beginning with student-centric narratives regarding clinical placements in Chapter Four. Chapter Five considered the organisational level connections and complex hinterland supporting clinical placement provision. The final findings chapter explored the nursing profession level view of the influences on nurse education, highlighting changes that have manifest over time.

In Chapter Seven, the findings were discussed and situated within the literature to examine what this study adds, reinforces and contributes to the understanding of clinical learning experiences. Bronfenbrenner's (1977) Ecological Systems Theory of Human Development was used to situate the collective study findings and model the complexity, context and continuums related to student development and the evolution of nursing over time. This concluding chapter, will present conclusions and recommendations arising from this study, consider the study's methodological strengths and limitations and include self-reflection and recommendations for future research.

8.3: Conclusions and recommendations

The conclusions and associated recommendations are presented in the following two sections. The first considers the broader theoretical or profession-oriented perspectives. The second section offers considerations for the practical aspects of clinical curricula development and clinical learning experiences.

8.3.1: Theoretical and profession-oriented recommendations

Recommendation*: A whole of system approach to clinical education needs to be strengthened and promoted to emphasise collaboration between the healthcare and higher education sectors within the context of the nursing profession. Modelling undergraduate nurse clinical education as a complex system highlights that, despite the perceived disconnect between healthcare and higher education, meaningful experiences and the development of the next generation of nurses, requires the input of both. A systems view also illustrates how changes in any part of the system, affects the whole and suggests the need to work with the complexities in creating meaningful learning experiences, rather than offer resistance against them.*

If nurse education, as the literature suggests (Allan 2010; Benner et al. 2010; Darbyshire & McKenna 2013), is at a critical point in its evolution, this study contends that ensuring students are provided with meaningful clinical experiences requires strategies that address the system as a whole, especially at the interface of the complex subsystems which have the students' transformation at their core. However, the reform or redesign of complex and intricate systems can appear overwhelming and risks, as Snyder (2013, p.6) suggests, 'systemic paralysis and confusion' or the 'temptation of oversimplification and laser-focused reforms'. Banathy (1991) cautioned that fragmented or reactionary, rather than solutions-focused approaches, can limit educational development due to 'reduce and resolve' type thinking and the inability to think outside the box. Betts (1992, p. 38) considers these factors to be examples of 'paradigm paralysis', and promotes a systems approach to reform the delivery of education.

Systems thinking is *contextual,* taking in the situation of a larger whole and shifts from analytical thinking, which takes a system apart to understand it (Capra & Luisi 2014). Therefore, to further develop innovation in the provision of meaningful learning experiences requires solutions that look beyond the component parts or basic structures and address the complexity, context and connections that comprise the system in its entirety. Engaging those involved in nurse education, at all levels, to be 'systems wise' (Kim 1999, p. 1), can develop systems-oriented thinking applied to the provision of undergraduate nurse clinical education. As Johnson (2008,

p. 1) proposed for school education, the value of the application of Bronfenbrenner's System Theory and consideration of inherent complexity of the system offers an 'appropriate and useful alternative to the linear models that often form the basis of educational research and policy'.

As NHS Scotland (2006) and Lake (2002) assert, nursing is an inherently complex phenomenon which is unpredictable and difficult to quantify. As clinical learning experiences are embedded in this unpredictable domain, the relationship between the structure of the clinical curriculum and each episode of clinical education is subject to a range of contextual influences. As proposed in the modelling of clinical education as an ecological system (Figure 7.1 p.154), meaningful experiences arise at the interface of three complex subsystems. These are the program of study, clinical placement setting and the student's personal domain. Each subsystem has its own inherent context, the program of study is embedded in the higher education institution, each clinical placement setting is part of the healthcare organisation and each student is an individual on their journey to becoming a nurse. These sub-systems, in turn, sit within the wider realms of organisational, professional and societal influence.

Prior to the shift of nurse education to the higher education system, a more singular, albeit complex system existed with hospital-based training. In this, often apprenticeship-based system, the student was directly aligned to becoming a future member of an organisation's workforce. The 'uncoupling' of health and education (Allen 2010, p.209) created two subsystems, with a shared contribution to nurse development. This shared partnership approach emerged as more developed at site 2, with the alignment and connection of the student to a NHS Trust, with the Trust investing in their future workforce. However, particularly at site 1, but also emergent at site 2, this study established the *student* as third subsystem with the personal circumstances of the contemporary student progressively exerting influence on the system as a whole. Factors, for example the need for paid work, influenced the student's preference for amount of clinical time and an older student demographic suggests the potential for more extensive responsibility outside of their program of study.

The need to adopt a whole of system view is further illustrated by current contextual shifts occurring in England that will impact the contemporary student. For example, the cessation of the student bursary may affect students' ability or desire to undertake long placements, a full range of shifts and effect retention as the *system* adapts and evolves. Further, politically driven change, such as Brexit[18], will result in the UK no longer being required to implement EU

[18] Brexit – used as a shorthand way of referring to the UK leaving the European Union - merging the words **Br**itain and **exit**. Accessed at http://www.bbc.com/news/uk-politics-32810887.

regulations (EU 2005/36/EC), which currently determines the 2300 required clinical hours for nursing programs. Concerns are also raised regarding the effects on EU nurses currently working in the system and future recruitment, as their loss will further compound issues in nurse shortages (RCN 2017). Nurse education and the provision of clinical learning opportunities is not immune to these changes and shifts in the system as a whole.

Though manifestations of the theory-practice divide were raised in this study, it was evident that connections, relationships and collaboration existed between healthcare and higher education. When these collaborations were working well, a shared vision of the future and goal of nurturing the next generation of nurses was generated. As Jordon et al. (2010) determine, seeing the whole and working not just with the structural elements in the system but understanding the process and function, is necessary to understand relational impact on the provision of clinical learning experiences. Instrumental to effective collaborations, at both sites, were the professional staff. As an under-represented voice in the dialogue on clinical placement provision, professional staff are positioned to offer a critical contribution to continued debate and reform.

Recommendation*: The development of nursing curricula, including the clinical component, that are responsive to the predicted short and longer term cycles of growth and significant change that are, and will continue to occur, in healthcare and in nursing, is necessary.*

Within Bronfenbrenner's (1986) Ecological Systems Theory, the chronosystem highlighted several time continuums within this study, related to the student, to being a nurse and to nursing. The student's continuum is their journey from student to becoming a nurse and consequently their learning and development needs and identity change over time. Though each student has a unique and potentially non-linear trajectory, many students in this study described their most meaningful clinical experience as the point on this continuum when everything came together; a point of transformation were the student identifies as a nurse. Yet, the student's transformation occurs within the constant evolution of the nurses role and of nursing's identity which generates two distinct, albeit linked continuums, as nurses and nursing respond and adapt to changing healthcare needs and provision.

The constant evolution of the nurses' role and nursing has two impacts. Firstly, the seemingly subtle significance of students being seen as *student nurses becoming nurses* and part of the continuum of the profession, was evident at many levels. As each student makes that professional transition as a nurse; the *nurse* the student identifies with and becomes today, will continue to evolve. Hence, students need to develop the ability to self-assess and evaluate their learning needs as part of the process of lifelong learning, an established and pertinent

concept (Davis, Taylor & Reyes (2014). Second, to truly innovate, longer or more projected curriculum cycles are required, to complement the 3-5 year curricula cycles, which are necessary to respond to short term change. As part of this, taking the *best of what is* forward rather than retaining the popular or traditional requires vision and leadership; this is not without risk. It was a challenge, initially, for some participants in this study, to engage with the appreciative inquiry phase to *dream.* The many inherent constraints, such as the regulatory requirements for clinical hours and block placement models require forward and creative thinking to be encouraged to truly innovate. Though the future is not easy to predict, flexibility and responsiveness will support greater adaptability.

Recommendation*: The further development, enhancement and/or support for professional nursing roles that promote the integration of the clinician-academic-researcher elements of nurses' contemporary identity, is required.*

Some of the academic staff in this study, drew attention to wanting the opportunity to retain or develop roles that supported integration of academic, clinical and/or research endeavours, with various combined roles considered. As Andrew and Robb (2011) have commented, nursing is yet to identify the optimum balance between academia and practice. The American Association of Colleges of Nursing (AACN 2016) report aimed at maximising nursing contribution to healthcare reform, highlights the need for a collaborative approach across academic and practice leaders. Developing these partnerships would contribute to optimising nursing care delivery, sharing the development of future nurses and better integrate research into nursing practice (AACN 2016).

The following section presents the recommendations and considerations that may inform and contribute to the practical aspects of implementing and developing clinical learning experiences.

8.3.2: Practically-oriented recommendations

Recommendation: *In the drive for reform, ensuring that the 'best of what is', is identified and protected going forward into the future is essential as the basis for innovation. In particular, the difficult to quantify components of meaningful clinical experiences, including the relationships and factors, such as being welcome, that promote student assimilation in the healthcare setting, need to be assured. The focus on designing for the student experience and capacity to meet their learning needs could be enhanced.*

Within the existing provision of clinical placements, at both study sites, students described experiences of clinical learning that were rich, relevant and purposeful. Yet, this study established a level of randomness in the way the components at the heart of the clinical

experience - a student, a supervising nurse and learning opportunities - are brought together. Consequently, there is no guarantee that a clinical learning experience will be of sufficient challenge or offer learning opportunities commensurate with the student's development, to move them forward on their journey to becoming a nurse. The descriptions of meaningful clinical experiences were indicative that meaningful experiences are *more than the sum of their parts.*

Knowing the structure or components of any system, does not necessarily predict its functionality or efficacy (Capra 2010). A successful placement experience was dependant on many quantifiable components but more so on less tangible factors. In particular, fundamental factors identified in this study were the people, relationships and patterns of behaviour they orchestrate and the synergy produced. At the microsystem level, in particular, (Figure 7.1) where healthcare, higher education and the student intersect, was the heartland of the placement experience. From the student perspective, some of the strongest insights into 'what works well' were at this microsystems level interface.

This study supports the findings of others who have identified distinctive patterns within this heartland, such as being made to feel welcome, belonging and being part of the team (Courtney-Pratt et al. 2012; Levett-Jones & Lathlean 2008), along with facilitative immersion and engagement with authentic practice. What this study adds is how these patterns were clearly evident at both study sites, despite the notable differences in the approach to supervision and duration of clinical placements. However, longer placements better facilitated the unfolding of the pattern sequence, with the potential for greater impact on the student's transformation. Two week placements did not readily support the student's ability to maximise the learning opportunities that may be available.

Shedroff (2009, p.2) advocates that 'if the elements that contribute to superior experiences are knowable and reproducible 'this makes them 'designable'. Though Shedroff's work focuses on experiences via interactions in the digital world, the concept of design built around what is known to work well, is prudent. A shift of collective thinking from the team or location-based placement to conceptualising *experiences* will further emphasise student-centred learning. To focus on the *experience*, Shedroff (2009, p.4) proposes this requires consideration of an 'attraction', an 'engagement', and a 'conclusion'. This process can be applied to the patterns evident in this study. Therefore being made welcome and part of the team ('attraction'), facilitated access to authentic practice ('engagement') and recursion and resolution for consolidation of learning ('conclusion'). Some of the key patterns in this study's findings, appear

amenable to enhanced design and their application can be included in student and student supervisor preparation for placements.

Recommendation: *Flexible or mixed models of clinical placement and student supervision are designed, developed and evaluated. Flexible approaches may better meet student needs and will be necessary if placement diversification is to be achieved.*

The notion that *one size does not fit all,* and more importantly moving forward, *will not fit all,* was an outcome of the study, evident at the level of the individual student, the clinical setting and placement duration. Increasingly, as changes occur within healthcare and higher education, the profile of the student cohort and the context and setting for clinical learning experiences will transform, and flexible rather than rigid models for clinical education and/or student supervision will become increasingly desirable. In addition, flexible models may more effectively address the students' attainment of competencies, graduate attributes and move towards the development of capability and continual professional development (Fraser & Greenhalgh 2001).

As students' needs vary across the 3 years of their program, differing models of supervision can offer advantages to support different stages of student development. For example, the clinical facilitator (or a clinical teacher) model may be effective in the first year, closely guiding students early in their development, and for example, sampling shifts rather than following a full roster could be appropriate. In contrast, mentorship style models of supervision may be advantageous for final year students and incorporate students following the full shift pattern of an RN to prepare for transition into the real world of practice. Adopting a tailored approach to supervision across the years may promote the interpretation of supernumerary status as a fluid rather than static phenomena. Early in the program, supernumerary status can drive the students' ability to meet their learning objectives, but evolve to increasingly engage students working as part of the team.

Flexibility was also seen as applicable to the clinical setting. The conclusion from this study builds on findings in the literature review, that varied or flexible approaches to placement models are feasible, as long as the components and patterns required for positive experiences are supported. As part of the projected shift in healthcare services to be more primary care focused (Tabish & Syed 2015), moving from acute care traditional medico-centric models will be required.

Within the clinical placement arrangements at Site 2, the Hub and Spoke model emerged as an example of an approach orientated to creating a *package of experiences.* Illustrative of a flexible model, the Hub and Spoke was seen as being able to accommodate, rather than attempt to

control, the unpredictable and non-linear student journey (or continuum). The Hub and the Spoke model allowed students to more effectively follow their learning objectives to develop an integrated view of the patient journey and cycle of healthcare. The Spokes allowed students to pursue objectives not available in their Hub and clinical areas unable to support a full or long placement had the opportunity to host students. This reflects Roxburgh et al.'s (2012) basis for the Hub and Spoke design, that the objectives drive the experience rather than being constrained by time and place.

A further aspect of *one size will not fit all* relates to the duration of clinical experiences. A long-standing debate in nurse education, for which there is a lack of evidence, centres on the optimal duration for overall clinical hours and for a clinical placement. Whilst no definitive conclusion can be drawn from this study, the findings add to the dialogue. Notable are the influences on preferred placement duration, for example those arising from the status of the contemporary student, such as the need for concurrent paid employment. Other factors included the student's interest in a clinical setting and nature of the nursing practice and their own career aspirations. Hence, revisiting the purpose of the placement could, for example, result in shorter *taster* placements and longer *core* placements for consolidation of key skills and longer placements at the point of transition to practice.

The governance body's rigid driver of 800 clinical hours (Site 1) has been considered to promote a philosophy oriented to quantity versus quality (Ralph et al. 2017). On the surface, it may appear that 2300 clinical hours (Site 2), would be preferable to 800 hrs (Site 1). However, whilst an 8 or 10 week placement certainly may allow for the student to orientate better than a 2 week placement, if the placement does not offer sufficient learning opportunities, any perceived advantage may be negated. A four week meaningful experience may outweigh a 10 week mediocre experience, requiring a paradigm shift in thinking from the time-bounded placement to assuring the appropriateness and quality of experience, to sufficiently prepare a new practitioner.

Recommendation: *The importance of the student supervisor role(s), regardless of model, needs professional and organisational level recognition and pro-active strategies as part of any clinical curricula design to ensure the appropriate selection, preparation and ongoing support for those RNs supporting and supervising students in the clinical setting.*

A strong conclusion in this study was the critical role of 'who the student works with' as the orchestrators of the student experience. The person in the role of the student supervisor and the RNs or educators working alongside the student were considered able to "make or break a

placement" and consequently exerted considerable influence on the student experience. This study adds to the many other reports in the literature (Courtney-Pratt et al. 2012, Gurkova et al. 2017, Sundler et al. 2014) which have demonstrated that relationships, though sometimes serendipitous in nature, are the key factor in whether a student's clinical experience is good, bad or indifferent. Many existing studies have specifically targeted supervision models as the subject of their investigations. In this current study, appreciative inquiry-based questioning broadly asked what worked well and drew numerous spontaneous comments on the significance of *who the student worked with* from academics, professional staff and students. All spoke strongly to the importance of the student supervisor and/or buddy RN, regardless of approach taken to student supervision.

However, there needs to be greater recognition of the significance of student supervision and development or strengthening of processes to support, develop and enhance those in roles working directly with students. Ensuring all student supervisors are aware of the patterns associated with student engagement (discussed earlier) and the importance of the Zone of Proximity (Vygotsgy 1978) would be indicated from this study. Developing the ability of student supervisors to engage students in practice and judge how much responsibility the student could handle or requires to develop further, will inform the safe negotiation of student interaction with practice.

Recommendation: *Clinical curricula need to incorporate sufficient preparation of nursing students in order for them to have the capacity to maximise engagement in clinical learning experiences.*

Recommendation: *Real world emersion in practice has to remain a fundamental part of nurse preparation. However, real world clinical experiences need to be optimised, enhanced and complemented via strategic articulation with a spectrum of simulation based learning activities. Such simulation activities can have a crucial role in promoting student preparedness for practice, refining skills and offering exposure to high stakes, low frequency clinical events.*

The student has a role in the relationships formed with their supervisors, nurses and members of the multidisciplinary team. Part of their preparation requires that students are able to move between the university and healthcare-based components of their program study. Students need to understand and negotiate their supernumerary status, to actively seek learning opportunities rather than being a passive observer and take ownership of their learning. Student also require skills in self-assessment of their developing skills and abilities to reciprocally engage in the student-supervisor relationship.

Being part of the team is a core factor in meaningful clinical experience and necessitates that the student is able to contribute to the work of the team. Seen as 'doing' nursing, sufficient skill acquisition was seen as a requirement, in this study, for students to engage with practice and contribute to the team. The academics, and some students, concluded that more effective use could be made of simulation-based and other techniques such as augmented and virtual reality to articulate with clinical experiences. These could be harnessed more effectively to prepare students to maximise the nuanced experiences within the clinical setting. Recursive practice to develop confidence could be enhanced prior to clinical placement and early in programs so students can move into the higher layers of professional development (DeMeester et al. 2017).

Though it is well established that learning experiences in authentic clinical settings contribute to the students' development as a nurses, this study offers contemporary affirmation that reality cannot be replicated and makes a unique contribution to the student experience.

Recommendation*: The promotion of strengthened collaboration between healthcare and higher education at the point of student transition to registered practitioner, is warranted. The development of combined bridging programs that lead into beginning clinical practice and which support early career nurses with ongoing education opportunities to consolidate their preparatory education, is required.*

The point of transition from student to new graduate was identified as an area to target for collaboration, development and enhancement as a critical point on the student's journey. Effectively managing the transition from student to RN, was seen as a bridge in addressing the perceptual theory-practice gap and ensuring new graduate preparedness for practice. Though transition programs are in place that support student transition to RN, they have been reported as variable in effectiveness and at risk of being under-resourced (Mellor & Gregoric 2016).

The alignment of the student with a NHS Trust in the UK gave the student an increased level of engagement with a destination clinical site. If such alignment cannot be achieved for the whole program of study, increased engagement with a preferred facility in the lead up to transition would be beneficial.

8.4: Strengths and opportunities in the research design

This thesis contends that approaches that prompt exploration can enlighten our understanding of the complexities in the provision of the clinical component of nurse education, within and across the varied models that exist. The contextual and relational aspects of clinical education emerge in this study as key influences on what works well and the occurrence of meaningful

experiences. Yet, this context can be highly variable from country to country, from state to state (in Australia), from organisation to organisation or even ward to ward within the same facility. This variability is further compounded by nursing taking place in diverse settings, with a spectrum of registered nurse roles and responsibilities.

Case study methodology, as advocated by Donnelly and Wiechula (2012), provided a means to examine the interconnected nature of the elements within clinical education, compared to taking a reductionist or cause and effect approach. In addition, case study supports the exploration of a phenomena within the real world, thus capturing the characteristics of those events in context (Anthony & Jack 2009). Anderson et al. (2005) advocate the merits of case study and incorporating concepts associated with complexity for the examination of systems, to highlight the importance of patterns and relationships and act as a means of viewing a given system as a dynamic whole.

In this study, the use of case study and appreciative inquiry promoted a systems view of the provision of undergraduate nurse clinical education. Unlike a reductionist, analytic view, systems oriented thinking focuses on the realities of the world and the how groups of interacting, related or interdependent elements come together, placing an emphasis on the *whole* (Kim 1999). Emphasising the whole enables the exploration and characterisation of the system of interest, inclusive of 'its environment and its components and parts' (Banathy and Jenlink 2004, p.47).

Aspects within the provision of undergraduate clinical education are readily problematised, such as in securing sufficient placements, managing large student cohorts and achieving consistency in student supervision. Hence, incorporating a stance guided by appreciative inquiry as an illuminating lens was invaluable. Appreciative inquiry guided data collection, encouraged participants to identify the strengths in current systems and capture the essence of what works well and how clinical teaching and learning could be enhanced. This process identified features of the two cases under study that need to be safeguarded as a basis for innovation, in what Mannix et al. (2006) propose, is the race for change. Appreciative inquiry and case study offer a solution-driven mode of inquiry that can be applied within the multiple local and international contexts for clinical education. As Richer et al. (2009) suggest, the use of the appreciative inquiry *dream* question promotes innovation rather than merely repeatedly fixing what is known and allowed participants in this study, to step away from *that's the way it is* focused thinking.

The research design shifted from ridged models of clinical education and supervision to a wider consideration of the systems, connections, relationships and patterns that underpin education

delivery. As few academics (and even fewer students) have experience of 2 or more differing approaches to clinical education, this design facilitated the ability to identify and synthesise an emergent appraisal of features within two approaches to clinical education across boundaries. Despite the differing context of the two cases in this study, similarities emerged suggestive of a level of internal generalisability (Miles & Huberman 2002). The scope for external generalisation to the wider nurse education arena (Miles & Huberman 2002) maybe less applicable. However, the recommendations based on the findings of this research, can inform those engaged in the design of nurse education. These recommendations encourage promotion of collaborative solutions and further robust dialogue on designing for the future of clinical education as an essential component of nursing education overall.

8.5: Methodological issues and challenges

Student recruitment was a methodological challenge at both sites in this study. When viewed as a percentage of total final year student populations (Sites 1 and 2), the student sample in this study is small. In such circumstances, consensus as to what constitutes an adequate response rate has been debated (Badger & Werrett 2005), as has the ability of a small sample to still be representative of the participant group. Throughout the data collection period, strategies were sought to address the challenges in recruitment by examining the contributory factors and possible solutions. The option to increase the number of study sites was considered, however, this necessitated the need to seek further ethical approvals, which was tempered by the constraints of the PhD timeframe, and hence this option was not pursued. In addition, the practicalities of recruiting across the existing study sites, in Australia and the UK, determined that maximising recruitment at the existing sites be prioritised.

There is lack of consensus about what constitutes a good response rate particularly in the context of qualitative research (Badger & Werrett 2005). In their review of research published in three nursing journals, Badger & Werrett (2005) found just over half reported the response rates, adding that response rates declared in the literature can vary widely. Shivers, Hasson and Slater (2017) questionnaire on satisfaction with clinical experiences had a 24% response rate which they reported as being considered a high response rate in comparison to similar studies. Henderson, Twentyman and Heel (2006) report a 52% participation rate of eligible students in their evaluation of the clinical learning environment. Studies may opt to describe the sample but not the participation rate. In Lovecchio, Di Mattio and Hudecek's (2015) pilot study of student satisfaction with clinical experiences, the sample is described but a relative overall participation rate is not included. In studies of clinical placement experiences the sample may be

predetermined, for example, driven by the percentage of a student cohort allocated to a particular placement type (Mulready-Shick et al. 2009).

In response to the low participation rate in this study, the factors influencing participation in survey based studies, particularly student orientated factors, were explored via the literature on survey based methodology. Prominent in the literature were considerations regarding student engagement in satisfaction and evaluative type surveys or questionnaires regarding their educational experiences. Three categories of influence were apparent – the potential participant and the inherent and extrinsic factors that influence participation, the research/researcher and the tool itself – the survey/questionnaire.

A range of participant-related factors which may affect recruitment can be identified. These include, the time or inconvenience required to complete a survey and survey overload (Adams & Umbach 2012). Nair, Adams and Mertova (2008) refer to 'survey fatigue' which may be pertinent in this current study as students were invited to complete a range of evaluative and student satisfaction surveys, some coinciding with invitations to participate in this study. Another factor is justification for participation for which Nair, Adams and Mertova (2008) promote that the researcher clearly articulate the purpose and consequences of the research to potential participants. A further factor is seen in Milton-Wildey et al.'s. (2014) study of student satisfaction with their nurse education program which achieved a response rate of 18% of students invited to participate. The study had an urban and a rural study site and a majority of those participating came from the urban campus, though the reasons for this are not fully elucidated.

Factors related to the research itself are the saliency of the topic or research question to participants (McColl et al. 2001). The mode of delivery of the research instrument has also been demonstrated to influence participation (Avery et al. 2006, Dommeyer, Baum & Hanna 2002). Whilst web-based, online surveys are increasingly used as alternate to paper based surveys, to evaluate education programs, Nulty (2008) suggest online approaches can result in lower response rates than paper based or other methods.

As the undergraduate student populations at both study sites were diverse, multiple factors may have influenced a student's decision to participate or not. An outcome of this study is an enhanced understanding of the compounding factors which make it difficult to engage, already heavily committed students, to participate in a research project. The challenges in recruiting students in this study reflect one of the study findings, in that contemporary students are often balancing full time study, clinical placements, paid work and potentially multiple additional

commitments, making their ability or willingness to commit to additional activities understandable.

A more robust planning and communication strategy, in the initial stages of the study particularly prior to the commencement of data collection could have been achieved, as recommended by Bennett and Nair (2010). However, several strategies to increase recruitment were incorporated into the current study. These included offering multiple formats for the survey - electronic and paper versions (Scott et al. 2011), the use of reminders via email and offering coffee vouchers as incentives (Abdulaziz et al. 2015).

The option to attend a nominal group technique focus group, as an additional or alternative participation activity did not promote recruitment. Despite these efforts, particularly to increase participation with the questionnaire, the response rate remained low. Consequently, the student findings may exhibit participation bias related to those who choose to participate.

Another limitation in this study is the absence of the views of healthcare-based staff who are frequently referred to in the narratives of the participants. Seeking their response to the same questions within this study is a logical extension of research in this field into the future (discussed below). In particular, the experiences of RN mentors (Site 2) and buddy RNs at both sites would further illuminate the findings and conclusions drawn from this study as their role and effectiveness as experience brokers featured in the student narratives, in particular.

This study took place at one Australian and one English university. Geographically and contextually, parts of England and Australia are different than the two sites represented in this this study. In Australia, for example, within NSW, some regional or remote areas in particular will have differing systems and affiliations to those at Site 1, hence, the need to avoid generalisation to other contexts.

8.6: Personal reflection

My interest in undergraduate clinical education was borne from my experiences particularly as a Director of Clinical Practice but also my wider career in nursing and nurse education in the UK and Australia. Ensuring that I maintained self-awareness of my own perspectives, potential biases and interpretation of the findings has been an essential element of my development. Undertaking this research has shifted my thinking in several ways, in relation to the subject matter, my role as academic and myself as an early career researcher.

With regard to the subject matter, I had long thought in terms of models of clinical education and having experience of the British and Australian systems, had pre-conceived such duration

and other set boundaries. My early thinking was influenced by the logistics, such as time and place and 'models' of clinical education. Now, my understanding centres on the nature of the student experience. The totally immersive engagement in this research process has challenged not only my thinking on this topic but how I now approach my thinking. The methodology was key in promoting and keeping an open mind and becoming a more inquisitive and reflexive inquirer.

As an academic and researcher, I have been drawn to be more aware of and open to the use of ideas, theories or concepts from other disciplines and their applicability of the field of nursing.

8.7: Future research

This study has contributed further understanding on the nature of meaningful clinical learning experiences and the complexities in their delivery. However, there is substantial scope for continued research into undergraduate clinical education and the findings in this study point to several aspects that warrant further investigation.

Firstly, the absent voice in this study is that of the clinical staff who are engaged with students in roles which include, student supervisors, mentors, buddy RNs, educators or managers. The opportunity to ask the same appreciatively-driven questions regarding their experiences and perspectives on what works well would be complementary and enriching to the findings presented here. In addition, if innovation is to occur within undergraduate clinical education, this must reflect the needs of all stakeholders especially relevant within the clinical setting

The findings are suggestive that the students may benefit from differing clinical education models or forms of supervision over their program of study. This echoes the findings in Roxburgh's (2014) study, where student participants suggested a mixed model of Hub and Spoke and Traditional placements. Therefore, to take a longitudinal view as to how student needs and perceptions change over time could drive a tailored approach to clinical learning over a program of study. The rationale in the current study was to invite final year students to participate as they had the most clinical placement experience to draw upon when identifying their best experiences. However, to ask all years 'what works well' and analyse by year may support the emergent idea that across the students' journeys, each year may require different things in terms of support.

The clear patterns that emerged in the findings contribute towards enhanced understanding of what may constitute best practice for clinical placements. Further exploration of the effect of

non-linearity and unpredictability and their effects on the student experience is indicated. The application of complexity theories could further investigate these features of complex systems.

Finally, the influence and impact of concurrent paid employment, particularly employment in the healthcare sector, needs investigation to identify how paid employment contributes or conflicts with students' development.

8.8: Chapter summary

This study has shown that meaningful clinical learning experiences have, do and will continue to make a unique contribution on the journey that makes each individual student nurse, *a nurse.* To address the emergent issues and challenges in the provision of meaningful clinical education experiences and to innovate in this space, an all-of-system approach is necessary. Recognising that clinical education occurs in context rich, complex systems underscores the importance of collaborative and creative endeavours.

The collective nursing profession needs to engage in the nurturing of the next generation of nurses. However, political, social and professional change will challenge, but can also inspire, the future of undergraduate clinical education and the student journey. It is therefore imperative to ensure what is demonstrated to *work well* is valued and safe-guarded as a basis for an innovative refashioning for the future, so that meaningful clinical learning experiences evolve and are co-created going beyond history repeating.

The design of clinical learning experiences can contribute to delivering not only *the* next generation of nurses but *next generation nurses*. Nurses and nursing as a profession need to drive the continuum forward.

'The best way to predict your future is to create it' Abraham Lincoln

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APPENDICES

Appendix 1: Publications associated with this thesis

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Review

The context, influences and challenges for undergraduate nurse clinical education: Continuing the dialogue☆

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SUMMARY

Introduction: Approaches to clinical education are highly diverse and becoming increasingly complex to sustain in complex milieu
Objective: To identify the influences and challenges of providing nurse clinical education in the undergraduate setting and to illustrate emerging solutions.
Method: A discursive exploration into the broad and varied body of evidence including peer reviewed and grey literature.
Discussion: Internationally, enabling undergraduate clinical learning opportunities faces a range of challenges. These can be illustrated under two broad themes: (1) legacies from the past and the inherent features of nurse education and (2) challenges of the present, including, population changes, workforce changes, and the disconnection between the health and education sectors. Responses to these challenges are triggering the emergence of novel approaches, such as collaborative models.
Conclusion(s): Ongoing challenges in providing accessible, effective and quality clinical learning experiences are apparent.

Introduction

Undergraduate nurse clinical education is acknowledged for its role in socializing nursing students to professional practice and standards and nurturing the thinking, doing and emotional attributes needed to assimilate learning and integrate into the workforce (Willis, 2012). Yet, this component of nursing programs can lack critical leadership and focus, be difficult to manage and is becoming more challenging, as demand for student placements intensifies (Smith et al., 2010). Critical commentary in the literature (Allan, 2010; Jackson and Watson, 2011), highlights concern that preparatory nurse education is facing emerging challenges from evolving healthcare policy, staff shortages and population changes, and these challenges are of local and international concern (Daly et al, 2008).

In this current climate, stakeholders risk looking for a 'quick fix' to what Jackson et al. (2013, p. 150) aptly call the "Achilles' heel of health care professional curricula", and seek reactive and short-term solutions. Donnelly and Wiechula (2012) caution that the nursing profession must seize the opportunity to engage in stimulating discussion on clinical education before political or financial constraints stifle creativity. To meet future demand for quality clinical experiences for students requires clear leadership with a vision of change to drive sustainable and future proof innovation (Clinton and Jackson, 2009; Keighley, 2013). 'Future proofing', according to Keighley (2013) is a process which determines future trends and generates forward thinking based on what is known today. The essence is that by future-proofing something – in this case clinical education – it will continue to be of value in the future.

Objective

This paper sought to develop a snapshot roadmap to contextualize the barriers and facilitators to the clinical education of nurses. The overarching research questions were:

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What are the inherent features in undergraduate nurse clinical education that impact its delivery?

What are the emergent challenges in the governance of undergraduate nurse clinical education?

How are innovations being implemented to address these challenges?

Method

The literature was reviewed using electronic search engines (CINAHL, Medline and Scopus) and using the following search terms—Undergraduate[All Fields] AND ("nurses"[MeSH Terms] OR "nurses"[All Fields] OR "nurse"[All Fields]) AND clinical[All Fields] AND ("education"[Subheading] OR "education"[All Fields] OR "educational status"[MeSH Terms] OR ("educational"[All Fields] AND "status"[All Fields]) OR "educational status"[All Fields] OR "education"[All Fields] OR "education"[MeSH Terms]). The World Wide Web was searched for English language literature to generate findings on nursing clinical education. These findings were synthesized using a generalized inductive technique using the overarching research questions.

The findings are presented in a discursive style to act as a primer for debate, continued dialogue and foundation to inform future scholarship in this intricate area. The discourse is presented in three parts, beginning with understanding legacies of the past and the inherent features in clinical education that influence its provision. A summary of factors indicative of the contemporary challenges follows, relating to: influences on supply and demand; the disconnect between healthcare and education; healthcare reforms and changes to the nurse's role; and the determination of fitness for practice. Finally, examples of innovative approaches conceived for future undergraduate nurse clinical education are summarised.

Legacies of The Past

Internationally, multiple approaches as to how the clinical component of undergraduate nurse education programs are conceptualized, described and delivered make this a challenging area for collective review. In many countries, including Australia, Canada, and the United Kingdom nurse education has evolved from the hospital-based apprentice training of the past to degree level preparation. Degree program curricula are frequently guided by education *standards*, issued by accrediting bodies, such as the UK's Nursing and Midwifery Council (NMC, 2010) and the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2012). These standards guide the requirements for students to achieve the necessary beginning level competency for registration, yet provide scope for flexibility and differentiation in local program content. With reference to the Australian context, Walker (2009) questions this flexibility as a potential risk, allowing for variable curricula able to produce a variable 'product'—the nurse graduate.

Regardless of the ideological shift from 'training' to 'education' (Bradshaw and Merriman, 2008), and the 'model' of clinical education, features emanating from the hospital apprenticeship models still prevail. This is evident in the common term 'clinical placement' which Roxburgh et al. (2012) suggest implies that learning can be contained within the boundaries of a physical location, specific team or time. As part of a rotational access model, students are allocated to various placements in different settings, with diverse patients and supervisors. The model may be driven by availability and competition rather than the educational needs of the curriculum or learner (Holland et al., 2010). This can result in disconnected experiences (Campbell, 2008) with students unsure how particular settings meet their specified or personal learning objectives (Mannix et al., 2006).

Historically, rotational models have centred on the acute care sector where high acuity, rapid patient turnover, specialization, patient safety and numbers of learners may not guarantee appropriate learning opportunities avail themselves. Lauder (2008) comments that acute care settings emphasize 'illness' and 'patients', thus promoting the medical model rather than person centred, social models of health. Continued reliance on the acute care setting will not adequately prepare students for primary healthcare or community based employment, growth areas within healthcare provision. Another common practice is for students to provide total patient care to increasing numbers of patients as they progress through their program of study. Benner et al. (2010) caution that there is a misguided assumption that this makes students more 'work ready' on completion and they suggest that alternate ways for students to progress, develop and increase independence are needed.

The move to tertiary education conferred supernumerary status on students, giving rise to the need for models of student supervision. In their review, Budgen and Gamroth (2008) identified 10 clinical (or practice) education models, which often emphasize the mode of student supervision, rather than an overarching approach to teaching and learning. A spectrum of differing models and definitions of student supervision has evolved with a variety of terms used, sometimes interchangeably, including 'supervising', 'mentoring', 'facilitating' and 'preceptoring'. As examples, mentoring utilizes clinically based nurses—the nurse *mentor*, with student supervision part of the nurse's standard role (Jokelainen et al., 2011). Alternatively in the *clinical facilitator* models, registered nurses (RNs) are employed by the higher education institution (HEI) to supervise students, typically in a 1:8 ratio and over several wards (Courtney-Pratt et al., 2012).

The preparation and governance of student supervisors, regardless of the model, also differ. In the UK, the Nursing and Midwifery Council's (NMC, 2008) *Standards to Support Learning and Assessment in Practice* detail a formalized, nationwide structure. In contrast, with no formalized national structure in Australia, the need for greater consistency in supervisor preparation and governance has been identified (Andrews and Ford, 2013).

Further variables are the numerical parameters of undergraduate clinical education. These include the total practice hours stipulated by governing bodies; the duration, number and type of placements or experiences; the range of shifts; and number and type of patients a student cares for. Illustrative of this is the disparity in student clinical practice hours within preparatory programs; the European Union requirement of 2300 h, for example, contrasts with Australia's minimum of 800 h (EU, 2005/36; ANMAC, 2012). The duration of clinical exposure, along with its organization and the complex issue of assessment of competence are factors to consider when student exchange and, more significantly, potential mobility of the global nursing workforce are considered (Dobrowolska et al., 2015). This may be particularly pertinent to countries reliant on a migrant workforce to sustain the nursing workforce.

These facets exemplify the complexities and anomalies that intrinsically exist in undergraduate nurse clinical education. In addition, the provision of clinical learning experiences is also challenged by more contemporary issues such as healthcare, workforce and population changes.

Challenges of the Present

Supply and Demand

The nursing workforce is aging, with the median nurse age, for example reported by the Australian Institute of Health and Welfare as 44.5 years and the Canadian Institute for Health Information stating 45.4 years (AIHW, 2012; CIHI, 2011). As this sector of the nurse workforce moves towards retirement, a looming void contributes to projected nursing workforce deficits in countries including Australia, the United Kingdom and US (NHWT, 2009; Sherman et al., 2013). In addition, high rates of attrition, especially amongst early career nurses further compound predicted workforce shortfalls (Doiron et al., 2008).

These deficits occur at a time of growing demand for healthcare services, driven by societal changes, such as the growing aged population, evident in many countries (European Commission, 2012) and greater nursing involvement in aged care, primary and sub-acute care settings (ANMAC, 2012; Smith et al., 2013). Paradoxically, as the world faces increasing numbers of individuals with disability, the evident contraction in the availability of clinical sites, creates a challenge in achieving scale in workforce development.

A traditional strategy to boost supply is increased capacity in nursing programs (Sherman et al., 2013). Buerhaus et al. (2013) also see large numbers of younger people entering nursing as key in delivering the growth in the nursing workforce over the period 2020–2030. The ramifications of this are demonstrated in Health Workforce Australia data (HWA, 2013) which shows that 11,046 students commenced Australian undergraduate nursing programs in 2005, increasing to 16,328 in 2011. This 48% increase in students, creates a substantial increased demand for quality clinical placements and impacts healthcare services and staff. Jackson and Watson (2011) and Smith et al. (2010) note how this contributes to a 'supply and demand' situation, increasing competition amongst providers of nurse education. With reported first year cohorts of 806 students (Salamonson et al., 2012) considerable local pressure is generated on healthcare to host clinical learning experiences for nursing students. Further, within these large cohorts diversity characteristics including age, English language proficiency and finances can negatively impact on clinical experiences and require attention to clinical placement design and delivery (Koch et al., 2014). Understandably, in this drive to increase 'quantity' it is debated whether sufficient attention has, will or can be given to the 'quality' of clinical education (Levett-Jones, 2007; Roxburgh et al., 2012).

Disconnection

The shift of nursing education into the tertiary sector has resulted in what Allan (2010) terms, an 'uncoupling' of health and education with a perceived lack of leadership for nurse education. O'Driscoll et al. (2010) case study of four UK health service trusts found that whilst ward managers had strategic responsibility for education and the clinical learning environment, they lacked a direct role in student learning. Responsibility for student supervision and education falls to the registered nurse who, focused on patient care delivery, can feel unprepared and unsupported in the supervisory role (O'Driscoll et al., 2010). Where the clinically based RN acts as the student supervisor (mentoring), issues with the lack of preparation, confidence, recognition, time and organizational support are potential barriers to effective supervision (Courtney-Pratt et al., 2012; Myall et al., 2008). Greater recognition of the role ward based RN supervisors play in students' development has been recommended, with managers supporting the RN's preparation and development for the role, underpinned with effective communication channels (Myall et al., 2008).

In contrast, in models of student supervision where the education institution provides the student supervisor, for example clinical facilitator models, other issues arise. Here both the supervisor (clinical facilitator or 'faculty') and student are 'guests' in a facility, necessitating that the supervisor must develop alliances to identify learning opportunities and engage facility staff in student support (Dickson et al., 2006). In this approach, the bedside RN continues to play a vital role guiding students when the facilitator is unavailable and Courtney-Pratt et al. (2012) established that heavy workloads, time constraints and sheer numbers of students can affect these 'buddy' RN's ability to spend time with students.

Healthcare Reform

Healthcare restructuring and reform have driven changes to the nurse's role with the increased prevalence of un-registered support roles, reducing the capacity of healthcare providers to host student clinical placements (Allan and Smith, 2009; Smith et al., 2010). In the UK, Allan and Smith (2009) found that the increase in Assistant in Nursing (AIN) positions has resulted in the registered nurses becoming the *prescriber* of care rather than the *provider* of care. Subsequently, one consequence is that students may not perceive 'essential or basic care' as the role of the registered nurse. Hasson et al.'s (2013) semi-structured interviews with unregistered healthcare workers (n = 59) found student nurses worked alongside them to deliver patient care, due to limited RN availability. Interviewees revealed that they were unofficially or informally involved in student education, teaching students basic clinical and non-clinical tasks. Similarly, Annear et al. (2014) explored the potential for care workers in the growing aged care sector to act as mentors to student nurses. However, overcoming student's initial negative attitudes and demonstrating the links between fundamental care activities, such as hygiene, to wider nursing competencies needed to be addressed to better conceptualize these facilities for placements. As yet not fully explored within the literature, these non RN roles and less traditional placement areas require consideration in workforce projection and planning due to their impact on diversification, skill mix and subsequent capacity to supervise and assess students.

Determining 'Fitness for Practice'

Within the nursing profession, there is an all too common phrase, that new graduate nurses need to "hit the ground running" (Cross, 2009: p. 57), indicative of a lingering perception that moving nurse education to degree based preparation has resulted in new graduates who are not 'fit for practice nor purpose'. Bradshaw and Merriman (2008) lament the limited clinical skills of new graduates and the loss of fixed syllabuses with regimented skills testing to prescribed standards. However, the current high expectations and the focus on practical skills as a marker for competence upon registration are influenced by wider issues such as workforce shortages, skill mix changes and escalating clinical demands.

The desire for new nurses to fill a void may be indicative of the reality and demands of the contemporary workplace (Chernomas et al., 2010) rather than new nurses' lack of preparedness or short comings of nurse education (Wolff et al., 2010). Holland et al.'s (2010) evaluation of the Fitness for Practice curriculum (UKCC, 1999) in Scotland, found new graduates were 'fit for practice' on registration, though lacking in confidence; an important factor but distinct to lacking competence. In their research on perceptions of 'practice readiness', Wolff et al. (2010; p. 191) argue that the debate on the merit of the 'technically' (apprentice) prepared nurse versus the 'professionally' (tertiary education) prepared nurse, are "divisive and out-dated". They propose the debate move towards achieving appropriate new graduate transition into various healthcare settings, where a myriad of influences, including staff shortages and emerging technologies impact their integration into the workforce (Wolff et al., 2010).

Nurse education and the competency debate are further fuelled by public opinion and media reaction, where sentimentality for the past, lack of insight into contemporary healthcare and romanticized nursing images are evident. Headlines in the UK media that suggest that degree educated nurses are "too posh to wash" or "too clever to care" (Fawcett, 2013) are myths dispelled by the Willis Commission (Willis, 2012). When the Australian healthcare system was under scrutiny, Jackson and Daly (2008) presented a thought provoking snapshot of letters from Australian metropolitan newspapers, many critical of the university educated nurses, harping back to the "good" old days and unappreciative of a well-educated nurse workface.

The response to these contemporary challenges varies from the establishment of government agencies, for example Health Workforce Australia (HWA) to independent commissions, reporting the 'health' of pre-registration nursing education (Willis, 2012). In addition, however, nurses are driving reforms to enhance the robustness of future solutions, as the following cases illuminate.

Implementing Innovation

Addressing the 'uncoupling' of health and education, Dedicated Education Unit (DEU) and related clinical education models promote collaboration between practice and education partners. Defined by Moscato et al. (2007, p.32), a DEU is a healthcare setting "developed into an optimal teaching/learning environment through the collaborative efforts of management, clinical faculty, and staff nurses", where all staff engage in student learning. Compared to standard models, Callaghan et al. (2009) found students in DEU's benefit from observing many nurses practice, engaging in team-based care and communicating within the multidisciplinary team. Recent studies continue to highlight benefits of this model. Moscato et al. (2013) identified their value in early identification of failing students. Mulready-Shick et al. (2013) found nursing students had a preference for DEU's over traditional placements with retention of skills such as teamwork and DEU's have been reported to support high quality learning experiences with strong mentoring relationships (Nishioka et al., 2014).

Another collaboration described by Nielsen et al. (2013), is the Oregon Consortium for Nursing Education (OCNE) model with nine education partners collaborating to re-design and diversify nurse education. The spectrum of clinical learning activities within the model can be orientated around a skill, a concept, or a case, building up to episodes of total integrated patient care. The reported advantages are sustained health-education collaboration and ability to effectively meeting student's needs via diverse yet complementary clinical learning activities appropriate to their level (Tanner et al., 2008). However, Ostrogorsky and Raber's (2014) evaluation of first year student experiences indicates the ongoing challenges to increase effectiveness and refinement faced by whole scale shift and redesign of clinical education.

The evaluation of a Hub and Spoke Model in Scotland, addresses Benner et al.'s (2010) observation that few clinical curricula allow students to follow patients over time and across healthcare settings (Roxburgh et al., 2012). This model provides flexible, student focused, interconnected experiences, with students based in a main location *(hub)* with alternate locations *(spokes)* offering learning opportunities not available in the hub. Evaluation shows promise as an alternative to the more traditional compartmentalized, placement style experiences (Roxburgh et al., 2012).

Austria et al. (2013) and Ruth-Sahd (2011) have looked at student dyads to create a community of learning. Students work in pairs with their assigned patient(s) and findings demonstrate enhanced student confidence, team work and decision making. Student dyads may increase capacity as fewer RNs and patients are required each day (Austria et al., 2013).

Finally, there is mounting interest and evaluation in replacing in-situ clinical hours with simulated practice experiences. Up to 300 h (13% of total hours) of clinical time in UK programs can be replaced by simulation learning activities (NMC, 2010). In the US, the National Council of State Boards of Nursing's (NCSBN) Simulation study is evaluating the replacement of up to 50% of 'traditional' clinical hours with simulation (Kardong-Edgren et al., 2012). The findings of this large-scale, randomized, controlled study state that equivalent end-of-program educational outcomes were achieved when high-quality simulation experiences replaced up to half of the clinical hours and that graduates were prepared for clinical practice (Hayden et al., 2014). Achieving, high quality simulation experiences requires clear learning objectives to articulate with the curriculum, sufficient high quality simulation resources including adequately prepared staff, and debriefing to facilitate learning (Arthur et al., 2013). As Berragan (2011) states simulation provides a safe environment for the development of clinical skills but must connect with actual clinical practice to be effective.

The diversification of healthcare systems, population changes, changing profile of the student body and budget considerations will continue to challenge how clinical experiences are designed and developed. Innovative, future aware, novel, and flexible approaches that maximize use of resources and learning opportunities are necessary to ensure students engage in learning and emerge ready for practice.

Conclusion

This is a pivotal time for the future of the practice based, clinical experience component of undergraduate nursing programs. The notion of going 'back to the future' is not a valid option. In many countries, healthcare, indeed society and public expectation have changed and for the nursing profession continue to do 'more of the same' is unsustainable and unlikely to meet stakeholder's needs.

Strategically, leaders in health care education need to be attentive to the impact their engagement in decision making, policy development and governance has on the undergraduate education and preparation of the future workforce. Finding ways to ensure the curricula, and crucially the clinical component, reflects the needs of all stakeholders, including students, and meets the evolving professional and societal needs both in the present and for the future, requires continued critical debate.

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Review

In pursuit of an optimal model of undergraduate nurse clinical education: An integrative review

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ABSTRACT

Clinical learning experiences are an essential part of nurse education programs. Numerous approaches to clinical education and student supervision exist. The aim of this integrative review was to explore how studies have compared or contrasted different models of undergraduate nurse clinical education. A search of eight databases was undertaken to identify peer-reviewed literature published between 2006 and 2015. Eighteen studies met the inclusion criteria. A diverse range of methodologies and data collection methods were represented, which primarily explored student experiences or perceptions. The main models of undergraduate nurse clinical education identified were: traditional or clinical facilitator model; the preceptorship or mentoring model; and the collaborative education unit model in addition to several novel alternatives. Various limitations and strengths were identified for each model with no single optimal model evident. Thematic synthesis identified four common elements across the models: the centrality of relationships; the need for consistency and continuity; the potential for variety of models; and the viability/sustainability of the model. The results indicate that effective implementation and key elements within a model may be more important than the overarching concept of any given model. Further research is warranted to achieve an agreed taxonomy and relate model elements to professional competence.

Contents

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1. Introduction

Clinical learning experiences are vital components of undergraduate or pre-licensure nurse education programs (Mannix et al., 2006). Nursing students acquire the skills, knowledge and attitudes necessary to enter the workforce through episodes of supervised practice. These experiences are significant in student progression, attrition and future employment decisions (Eick et al., 2012; Hamshire et al., 2012).

Global demand for new nurses to replace an aging workforce and supply the growing healthcare sector is placing unprecedented demand on sourcing clinical learning experiences. Concurrently, the introduction of unregistered healthcare workers' roles results in fewer registered nurses to supervise students (Hasson et al., 2013). Hence, there is re-vitalised interest in determining effective, sustainable options for clinical learning experiences and student supervision (Cross, 2009; Jackson and Watson, 2011). When clinical education is being increasingly scrutinised, exploring the evaluation of clinical education models is opportune (Willis, 2012).

Various approaches exist for the provision of clinical learning experiences. There are multiple practice education or supervision models (Budgen and Gamroth, 2008; HWA, 2012) and the wide-range of clinical settings, patients, staff and supervisors each student encounters, all influence learning opportunities (Papp et al., 2003). Further compounding this diversity is a lack of unified terminology, making it challenging to compare and contrast differing clinical education models.

Enhanced understanding of the elements contributing to positive learning experiences is needed to best prepare students for the challenges of the health care workforce. Factors known to promote quality learning experiences for students include feeling that they are welcome, they belong, are valued as learners and can contribute to the healthcare team (Bradbury-Jones et al., 2007; Levett-Jones et al., 2007). Also, crucial is the development of supportive relationships between students, staff and supervisors (Myall et al., 2008; Saarikoski et al., 2002). Further key elements are sufficient learning opportunities, adequate student and supervisor preparation and sufficient support for supervisors (Courtney-Pratt et al., 2012).

Despite this awareness, quality clinical experiences do not always eventuate (Brown et al., 2011; Nielsen et al., 2013; Willis, 2012). Poor quality placements and unsatisfactory learning experiences are reported (Andrews et al., 2006; Brown et al., 2011; Ip and Chan, 2005) and may influence attrition from undergraduate nurse education programs (Crombie et al., 2013; Eick et al., 2012). This review sought to identify if there was an optimal model of clinical education and/or student supervision to maximise learning outcomes. In addition, exploration of the methodological approaches to evaluating differing models in the included studies may inform future scholarship in this area.

2. Aim

The overall aim of this integrative review was to identify, describe and critically review studies that from the student perspective compared or contrasted clinical education models, including models of student supervision, within undergraduate nursing programs. The two main objectives of the review were to:

- Describe the methodological approaches taken in each study and consider if any challenges were encountered.
- Integrate the findings from the studies to inform our understanding of undergraduate nurse clinical education and establish if an optimal model(s) emerged.

3. Methods

3.1. Search methods

An integrative review using a systematic approach was employed. This review method supports simultaneous inclusion and examination of "diverse methodologies" generating a comprehensive approach to address the objectives of this review (Whittemore and Knafl, 2005, p.547). The literature search was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis checklist - PRISMA (Moher et al., 2009). Eight electronic databases were searched: Academic Search Complete, CINAHL, Medline Ovid, ProQuest Health and Medical, Scopus, PsychInfo plus the Joanna Briggs Institute EBP Database and Cochrane Library. Hand searching of nurse education journals and references lists of included papers was undertaken. The search terms were: clinical education, practice education, practice learning, clinical learning environment and undergraduate, student, pre-registration and model/models, nurs*, nursing, nurse. In order to capture studies investigating contemporary curricula the search was limited to the last 10 years, Jan 2006–Dec 2015. Inclusion criteria were: 1) English language; 2) peer-reviewed; 3) compared models of undergraduate clinical education/student supervision; and 4) participants were preparatory nurse education program students. Papers excluded: 1) editorials, opinion pieces, conference abstracts; 2) review papers; or 3) non-English language.

Table 1
Reasons for article exclusion.

Reason	Number
Focus on one model and/or no specific intent to compare/contrast models	18
Papers are descriptive, implementation or non-research based paper	9
Not specifically related to undergraduate clinical education/supervision models	5
Participants are preceptors, education/clinical staff, recent graduates	2
Mentors' views of student supervision	1
Administrative/support systems for supervisors	1

3.2. Search outcome

Fig. 1. Provides the process to reduce and evaluate papers. Upon full paper review, 36 papers were eliminated as indicated in Table 1.

3.3. Quality appraisal

Twenty papers were appraised using a framework supporting quality assessment across various methodologies (Hawker et al., 2002). Evaluation included, determining the congruency between aim and methodology, appraising the data analysis, presentation of findings, discussion and ethical considerations. Neither sample size nor population was appraised given their diversity. Two studies were excluded. The first (Moscato et al., 2007) presented an informative, yet descriptive account of the implementation of a clinical education model. The second (Hendricks et al., 2013), lacked methodological detail, such as the recruitment processes. The final review comprised 18 studies (Table 2).

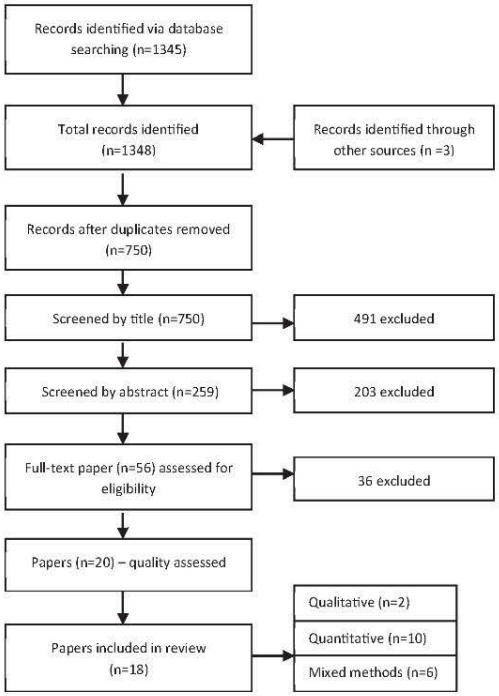

Fig. 1. Literature review flow chart.

3.4. Data extraction and synthesis

A two phase data extraction process was undertaken. Firstly a matrix was created to collate the various study designs, methods, objectives and study populations in order to describe the studies in the review. Second, the findings, identified in each paper were extracted and organised under the model of clinical education or student supervision the finding was attributed to. These data were then coded inductively into categories as described by Miles et al. (2014) that transcended the models of education or supervision. Data comparison then followed an iterative process to identify potential patterns, themes or relationships across the data (Whittemore and Knafl, 2005). Initial themes were reviewed and refined to capture the essence of each theme, which was then defined and named (Braun and Clarke, 2006).

4. Results

The results are presented in three sections. 1) the characteristics of the studies (Table 2); 2) a summary of findings from the studies, tabulated under broad clinical education/supervision model headings; and 3) findings from this review - the emergent themes which transcended the models under investigation.

4.1. The characteristics of the studies

4.1.1. Overview of included studies (Table 2)

The included studies are presented in Table 2. Seven papers originated from Australia; five from Queensland (Henderson et al., 2006a, 2006b, 2006c; Nash et al., 2009; Walker et al., 2013), and one each in New South Wales (Croxon and Maginnis, 2009), and Victoria (Newton et al., 2012). Of the Queensland papers, the three Henderson et al. (2006a,b,c) papers report findings from one larger project. The remaining studies were predominantly from the United States of America (Lovecchio et al., 2012; Mulready-Shick et al., 2013; Nishioka et al., 2014; Smyer et al., 2015), Europe (Gustafsson et al., 2015; Hellström-Hyson et al., 2012; Roxburgh, 2014; Sundler et al., 2014; Warne et al., 2010) plus single studies from Iran (Parchebafieh et al., 2014) and Saudi Arabia (Omer et al., 2013).

The duration of clinical placements varied, ranging from 32 h (Parchebafieh et al., 2014) to 42 weeks in Warne et al.'s (2010) study, with a mean of 6.4 weeks in the same study. Students at various stages of their progression are represented and clinical settings ranged from single site, single speciality studies (Hellström-Hyson et al., 2012) to single site, multiple specialities (Omer et al., 2013). The study approach could be considered 'direct' where participants experienced two or more models of clinical education/supervision, and draw from contrasting experiences or *'indirect'*, were each cohort of participants only experienced one model under investigation.

4.1.2. Study design, study objectives and data collection methods

Study designs and data collection methods were predominantly

Table 2
Included studies - presented alphabetically N = 18.

Author (year)	Location	Study objective	Study design, participants, data	Methods	Direct or indirect[a]	Education/supervision models in the study[b]			
						Trad.	Prec.	CEU+	Other
Croxon and Maginnis (2009)	Australia	Student experiences, achieving learning objectives, practicing clinical skills, availability/support by preceptor/clinical facilitator.	Mixed methodology, 2nd year BN students (n = 20). Single site.	Questionnaire Likert scale & open-ended questions.	Direct		Y		Cluster
Gustafsson et al. (2015)	Sweden	Student perceptions of nurse teacher role in 2 differing models.	Mixed methodology, 3rd year students (n = 114), Model A – University nurse teacher n = 53, Model B Clinical nurse teacher n = 61. Interviews n = 8.	Interviews and CLES + T (Clinical Learning Environment Supervision + Nurse Teacher scale).	Indirect				Y
Hellström-Hyson et al. (2012)	Sweden	Student experiences 2 supervision models. Seven week traditional placement and 2 weeks student ward.	Descriptive qualitative study, final semester students (n = 8).	Semi-structured interviews.	Direct	Y			Y
Henderson et al. (2006a)	Australia	Student's perceptions of psycho-social characteristics of clinical learning environment in 2 models.	Survey design. 1st year students, n = 33, traditional model and n = 31, collaborative education unit (CEU) model.	Survey using Clinical Learning Environment Inventory (CLEI)	Indirect	Y		Y	
Henderson et al. (2006b)	Australia	Student's perceptions of psycho-social learning environments with 2 models.	Pre-test/post-test quasi experimental design. 2nd & 3rd years. Pre-test, n = 370 traditional model. Post-test n = 287 traditional model and n = 83 CEU model.	Survey using CLEI.	Direct in the intervent-ion group	Y		Y	
Henderson et al. (2006c)	Australia	Student's perceptions of psycho-social characteristics of the clinical learning environment in 3 models.	Survey design. 1st, 2nd, 3rd year students, n = 399. Year 1 n = 34 traditional model, year 2 n = 50 CEU and n = 156 traditional, Year 3 n = 64 CEU, n = 79 traditional, & n = 16 preceptorship	Survey using CLEI.	Indirect/ direct	Y	Y	Y	
Lovecchio et al. (2012)	USA	Student's clinical experiences of 2 models -modified Dedicated Education Unit (DEU) with Clinical Liaison Nurse (CLN) & traditional model.	Quasi experiment: post-test only, non-equivalent control group. Junior & senior students. Convenience sample n = 40 experimental group and n = 14 traditional model.	Survey using CLEI.	Indirect	Y			CLN
Mulready-Shick et al. (2013)	USA	Whether DEU model enhances educational quality i.e. experience, clinical learning and quality & safety competency.	Evaluation study, students randomly allocated to two models. Junior students - n = 111 DEU and n = 54 traditional model.	Surveys - Student Evaluation of Clinical Education Environment (SECEE), 2 author developed surveys and student assessment data.	Indirect/ direct	Y		Y	
Nash et al. (2009)	Australia	Experiences specific to transition, enhanced DEU model and traditional model.	Mixed methods, pre/post-test survey, final year students, n = 92. Transition project model n = 29, traditional model n = 63. Focus groups n = 15	Survey and focus groups.	Direct	Y	Y		
Newton et al. (2012)	Australia	Student experiences of 2 models. **MASH** a tertiary industry collaborative model, underpinned by preceptorship – students assigned home base, preceptor and consistant clinical teacher.	Longitudinal quantitative study. 2nd & 3rd year students. Traditional model, clinical teacher n = 194, traditional model, clinical teacher and preceptor n = 165, & MASH model, clinical teacher and preceptor n = 97.	Surveys - modified Clinical Learning Environment Inventory (CLEI). Component of larger study.	Indirect		Y	Y	
Nishioka et al. (2014)	USA	Student perceptions of 2 clinical education models	Repeated measures design, junior and senior baccalaureate & masters students. 6 focus groups: n = 32. Surveys 473 students, returning 2–4 surveys (n = 1053).	Focus groups and CLES + T (Clinical Learning Environment Supervision + Nurse Teacher scale).	Direct	Y		Y	
Omer et al. (2013)	Saudi Arabia	Student perceptions of two models of Preceptorship. ***Model A*** education employed preceptor, allocated 2 patients and 4 students.Model ***B*** ward nurse allocated 6–7 patients and 1 student.	A descriptive, exploratory, quantitative survey study. Model A n = 57 in Adult wards, Model B n = 53 on maternity and paediatrics	Surveys. Moore's Preceptorship Evaluation Survey (PES).	Indirect/ direct	Y	Y		
Parchebafieh et al., 2014	Iran	Effectiveness of the Clinical Teaching Associate (CTA) model (seconded ward RN supervising students) on clinical learning outcomes/student satisfaction.	Randomised controlled trial intervention and control groups. Year 3 students, n = 28 CTA group & n = 32 control group traditional model.	Student satisfaction questionnaire, written exam and summative assessment.	Indirect	Y			CTA model
Roxburgh (2014)	UK	Student perceptions of two Clinical Education Models.	Qualitative part of larger study. 2nd year students (n = 10 adult program).	Focus groups.	Direct	Y			Hub & Spoke
Smyer et al. (2015)	USA	Differences in academic outcomes between students in a DEU and a traditional model	Longitudinal quasi-experimental repeated measure design, n = 144. DEU n = 90, traditional n = 54.	The Health Education System Inc (HESI) exams – as baseline, post clinical and on RN exit	Indirect	Y		Y	

Table 2 (*continued*)

Author (year)	Location	Study objective	Study design, participants, data	Methods	Direct or indirect[a]	Education/supervision models in the study[b]			
						Trad.	Prec.	CEU+	Other
Sundler et al. (2014)	Sweden	Student experiences of clinical learning environment related to supervision	Mixed methods, cross sectional study. Final year students at 3 universities Convenience sample n = 185 students. Personal preceptor only n = 54, several personal preceptors n = 107 and patient room with numerous preceptors n = 24	Survey CLES + T (Swedish version) + 1 open-ended question.	Indirect		Y		Patient rooms
Walker et al. (2013)	Australia	Students' perceptions of support two models of supervision	Cross sectional qualitative & quantitative study. Participants across three years BN (purposive sample n = 159).	Author(s) developed online survey. 22 closed and 3 open items.	Indirect	Y	Y		
Warne et al. (2010)	Multiple	Factors enhancing student experiences in clinical practice.	Quantitative Survey design. Pre-registration students at 7 polytechnics and 10 university colleges across nine countries (n = 1903).	Survey. Validated CLES + T translated into various languages.	Indirect	Varied			

[a] 'Direct' participants experienced two or more models of clinical education/supervision, 'indirect' two cohorts of participants but each experienced only one model.
[b] Education or supervision models included: Trad = Traditional, Prec = Preceptorship or mentorship model – (NB: MASH = an acronym constructed from the names of the university and healthcare organization concerned), CEU+ = Collaborative Education Unit, Dedicated Education Unit models or other partnership based models, Other = models not in other categories.

survey/questionnaires with nine studies utilising established and validated tools. Five studies used the Clinical Learning Environment Inventory (CLEI) scale (Henderson et al., 2006a, 2006b, 2006c; Lovecchio et al., 2012; Newton et al., 2012). Developed by Chan (2002) the scale evaluates six domains; individualisation, innovation, satisfaction, involvement, personalisation and task orientation. Another scale, the Clinical Learning Environment Supervision and Nurse Teacher (CLES + T) scale was used in four studies (Gustafsson et al., 2015; Nishioka et al., 2014; Sundler et al., 2014; Warne et al., 2010). The original CLES scale (Saarikoski and Leino-Kilpi, 2002) has five sub-dimensions; ward atmosphere, leadership style of the ward manager, premises of nursing care, premises of learning on the ward and supervisory relationship. The dimension of nurse teacher in clinical practice (CLES + T) was added subsequently (Saarikoski et al., 2008).

The outcome measures centre on student experiences or perceptions of clinical education and consequently, this review presents a student-centric view. Seven studies (Croxon and Maginnis, 2009; Gustafsson et al., 2015; Hellström-Hyson et al., 2012; Omer et al., 2013; Parchebafieh et al., 2014; Sundler et al., 2014; Walker et al., 2013) focus on student experiences of supervision models. Whereas, Lovecchio et al. (2012), Newton et al. (2012), Nishioka et al. (2014), Roxburgh (2014) and Mulready-Shick et al. (2013) endeavour to explore the overall model of clinical education. Nash et al. (2009) specifically compares two forms of transition placement for final year students. Few studies endeavour to measure learning outcomes or competency attainment, however Mulready-Shick et al. (2013) includes student grades and exam results, Parchebafieh et al. (2014) consider knowledge acquisition and Smyer et al. (2015) outcome measure is academic performance.

4.1.3. Methodological challenges identified by study authors

All but four studies explicitly consider the challenges or limitations within their research. These comprise the numerous contextual variables, including: program duration, stage of student progression, variety of clinical settings, size of facility, supervisor experience, participants' prior experiences and personal characteristics. For example, Henderson et al. (2006c) question if the perceived 'excitement' of some wards influences student evaluation of their experience. Gustafsson et al. (2015) commented on the potential methodological constraints afforded by the many stakeholders involved in the provision of clinical education. Finally, small sample size overall and limited size of sub-groups in study populations was acknowledged by these authors Roxburgh (2014); Henderson et al. (2006c); Lovecchio et al. (2012). Parchebafieh et al. (2014) noted this as a potential impact on the statistical ability to differentiate between study groups in their randomised control trial.

4.2. Summary of findings from the studies, organised under broad clinical education/supervision model headings

Whilst terminology varied, clinical education or supervision models essentially fell into 3 main groups plus several novel alternatives as described below. Given local variation and contextual constraints, whilst these headings create a review framework, they are neither discrete nor exclusive. Table 3a and b summarise the key findings utilising these models as a guide.

4.2.1. Terminology

4.2.1.1. The traditional model (or block or rotational placement model). Centres on an education sector funded clinical facilitator (or *faculty*) as primary instructor for a group of students (n = 8) across several wards/units, with students 'buddied' with registered nurses each day (Courtney-Pratt et al., 2012). As each placement may be in a different ward or facility this creates the rotational aspect. The cluster model variant, co-locates students on one ward/unit, affording increased clinical facilitator contact and peer support (Croxon and Maginnis, 2009).

4.2.1.2. The preceptorship model (or mentorship model). The central tenet is a 1:1 supervisory relationship between student and health facility employed RN with Warne et al. (2010) observing trends towards such models. Preceptorship needs sufficient time and support to function and is impacted by staff shortages and busyness of the clinical setting (Walker et al., 2013). Gustafsson et al.'s. (2015) study focuses on the clinical teacher role in supporting the preceptorship model.

4.2.1.3. Collaborative models (or partnership models and dedicated education units). Underpinned by education industry collaboration, the majority or all student placements occur in one healthcare

Table 3a
Summary of key findings. Findings related to the education or supervision models in each paper: Traditional and Collaborative Education Unit (CEU) models.

Author (year)	General findings	Specific findings for models studied	
		Traditional	Collaborative education units
Henderson et al. (2006a)	Satisfaction high for both models.	Traditional	The Clinical Learning Environment inventory (CLEI) scores higher for collaborative model, only significant for the *personalisation*. Indicative of greater concern for student welfare/learning.
Henderson et al. (2006b)	High levels of satisfaction in existence already, prior to the introduction of a collaborative model.	Traditional	Collaborative model significant differences post-test for *student involvement, satisfaction, personalisation and task orientation*. Indicative student's unique learning needs are addressed.
Lovecchio et al. (2012)	Supportive of academic–practice partnerships for clinical learning	Traditional	Preference for Clinical Liaison Nurse model (CLN), statistically significant for the CLEI domains - *task orientation, satisfaction and individualisation*. Indicative benefit of students working with clinical staff plus faculty member.
Mulready-Shick et al. (2013)	Both groups reported positive clinical experiences.	Traditional	DEU - significantly more positive learning experiences. Greater time spent in instructional activities, engaged with patient care and higher supervision quality. No impact overall on academic performance.
Nash et al. (2009)	Scope for differing transition placements that suit student's learning style/needs.	Traditional -participants in either model more prepared to transition to RN role.	Trend towards students being more prepared but not significant. Benefits - experiencing the 'real world', a realistic shift pattern, team work & understanding of learning needs.
Newton et al. (2012)	Student centredness key aspect of positive learning environments	Traditional	MASH model more positive for CLEI factor of *student centeredness* - highlights clinical teacher role important for continuity & relationship development.
Nishioka et al. (2014)	Both models valued – learn discreet skills in traditional model and 'nursing' in DEU.	Traditional - quality of learning unpredictable, lack of time with faculty member, but able to link theory to practice. Operational and communication structures could be barriers to effective education. Potential for ambiguous roles and unwelcoming wards.	Dedicated Education Unit – treated as a nurse not a student, less left to chance. Overall DEU's more conducive to learning – clearer leadership, welcoming atmosphere, individualisation and commitment to teaching.
Smyer et al. (2015)	No significant differences between DEU and Traditional model student scores on academic outcome measures (HESI scores)	Traditional	Dedicated Education Unit – students were considered not to be advantaged or disadvantaged academically by the implementation of the DEU model. Students only participated in the DEU model once so the authors question if differences may emerge with greater exposure.

organization and all staff engage in teaching and support. The implementation, constancy and sustainability of collaborative models required commitment from both parties. These models promote student welfare and individual learning (Henderson et al., 2006a, 2006b, 2006c) and generate 'real world' experiences for students.

4.2.1.4. Other models: Hub and Spoke model, student wards. In Hub and Spoke models, students belong to a 'hub' facility, with a series of 'spokes' experiences away from the main hub to develop understanding of the patient journey and care pathways (Roxburgh, 2014). In student ward models, students work in pairs and are jointly responsible for four patients (Hellström-Hyson et al., 2012). Under supervision, the model promotes collaboration, shared learning, continuity and patient engagement promoting greater independence in care delivery.

4.3. Findings from this review: emergent themes which transcended the models under investigation

Despite the diverse approaches to clinical education or supervision within this review, several themes emerged, independent of any particular model.

4.3.1. The central role of interpersonal relationships

The significance of the interpersonal relationships influencing students' satisfaction within the clinical learning environment has been consistently demonstrated in the wider literature (Papastavrou et al., 2010; Saarikoski et al., 2008). In this review the importance of relationships was demonstrated across the various models studied. Warne et al.'s (2010) large scale study, amongst others, correlates the quality of the supervisory relationship and student satisfaction with clinical experiences. It may be expected that differing forms of supervisory relationship offer their own particular strengths and this was demonstrated in several studies. Gustafsson et al. (2015) examined student experiences of support received from nurse teachers and, when employed directly by the healthcare care facility, their connectedness to clinical practice ensured they are well informed about day-to-day 'in situ' practice which was considered an advantage. In collaborative models, ensuring student integration into the nursing team promotes student engagement with the learning environment (Henderson et al., 2006b; Lovecchio et al., 2012; Newton et al., 2012). This is also evident in Nishioka et al.'s (2014) study where the supervising RN's relationship with the facility, unit and patients promotes a positive, welcoming, personalised learning environment for students, with a consistent commitment to teaching. However, Hellström-Hyson et al. (2012 p.109) warn of a potential 'novelty' effect, which may influence finding related to relationships, were by early adopters of innovation are those inherently motivated to host and nurture students (Henderson et al., 2006b; Nishioka et al., 2014). Lovecchio et al. (2012 p.611) agree as settings adopting their Clinical Liaison Nurse model were "historically welcoming and helpful".

In traditional models, the clinical facilitator has a close relationship with the education provider and connection to curricula and students stage of development. Gustafsson et al. (2015) found university employed clinical teachers had sound theoretical knowledge and were able to provide 'neutral' support for students

Table 3b
Summary of key findings. Findings related to the education or supervision models in each paper: Traditional, and preceptorship or other alternate models.

Author (year)	General findings	Specific findings for Models studied	
		Traditional	Other model(s)
Croxon and Maginnis (2009)	Both models supported 'hands on' practice & improved confidence.	May suit 'quiet' students. Preceptors require sufficient time for role.	**Cluster model:** increased availability and time from the clinical facilitator. Provides peer support.
Gustafsson et al. (2015)	The two models have different strengths.		**Preceptorship with either a University employed nurse teacher (UNT) OR a healthcare/clinical employed nurse teacher (CNT).** CNT's had greater ability linking theory to practice and their connectedness to clinical practice was an advantage. UNT's were considered knowledgeable and supportive especially if students had, for example, conflicts with their preceptor.
Hellström-Hyson et al. (2012)		When 'buddied' with RN, students feel like a 'helper", unable to see overall context and lacked control over patient care.	**Student wards** - pairs of students collaborate to problem solve, organise care delivery and develop independence. Sense of continuity, engagement with patient care.
Henderson et al. (2006c)	Final year students need longer placements and time for integration.	Traditional	**Preceptorship and Collaborative Education Unit**: Preceptorship preferred for enhanced student engagement (NB small sample size), mirroring the real expectations of the RN. CEU - higher CLEI scores but only significant for *personalisation*
Omer et al. (2013)	Preparation required to move between varying supervision models.	Education provider funded Clinical Teaching Assistant (novel model here). Increased student satisfaction - improved teaching, role modelling and learning.	**A pre-existing preceptor model** - RN with full patient load supervising 1 student. Used in specialist areas e.g. paediatrics. Limited supervisory support/student advocacy.
Parchebafieh et al. (2014)	Overall satisfaction the same. Both effective enhancing knowledge/clinical skills.	Traditional, students found the faculty member promoted linking theory to practice.	**Clinical teaching associate model** (adapted preceptorship) effective for learning patient communication and skills. Potential for collaboration between education and health partners
Roxburgh (2014)	Overall, preference for mixed model hub & spoke and traditional.	Rotational aspect creates anxiety, impacts student's belonging, acceptance as team member, and continuity in learning/development.	**Hub and Spoke model** - students had sense of belonging (aligned to geographical location, role models and understanding care pathways). Developed lasting confidence.
Sundler et al. (2014)	Overall, students had positive experiences of the clinical learning environments	CLES + T domains *supervisory relationship and pedagogical atmosphere* rated significantly greater for preceptorship model. Continuity/quality of supervision emphasized.	**Student training rooms** - dissatisfaction linked to multiple supervisors, issues with attitudes, continuity and 'pitching' supervision at the right level.
Walker et al. (2013)	Quality of student support matters most, not the model. Both having merit.	Traditional group supervision — preferred. Participants significantly more likely to agree facilitators challenged thinking & problem solving via reflection, built on existing knowledge/skills.	**Preceptorship model** - potential for too many preceptors due to staff shortages and busyness of the clinical environment.
Warne et al. (2010)	Participants in general were satisfied with their clinical placements.		**Multiple options** over 9 countries: Overall, students evaluated clinical experiences positively, particularly for CLES domains *supervisory relationships and pedagogical atmosphere.* Longer placements associated with greater satisfaction. Most important factor in satisfaction was supervisory relationships.

due to their indirect link to clinical areas. Walker et al. (2013) found facilitators can encourage problem solving, reflection and linking theory to practice, as did Parchebafieh et al. (2014) though there are many contextual differences observed in the studies with the latter notably having the shortest duration of placement in the included studies.

4.3.2. *Consistency and continuity in clinical education delivery*

Nishioka et al. (2014) found models must be consistently defined and implemented to be effective, including establishing key roles and pathways for successful communication. In studies of collaborative models, consistency is important in the underlying philosophy which is evidenced in staff's consistent approach to welcoming, engaging and teaching students (Mulready-Shick et al., 2013; Nishioka et al., 2014).

A consistent supervisor or contact person who understands and monitors students' knowledge, abilities and skill level stimulates student learning and development (Newton et al., 2012; Sundler et al., 2014). In Newton et al.'s (2012) collaborative model, a clinical teacher provided a consistent point of contact resulting in statistically significantly CLEI scores for 'student centeredness' compared to the traditional model. In contrast, Roxburgh (2014, p43) found students in a traditional rotational model, describing "going backwards" or starting again as they moved through placements. Disrupted continuity resulting from multiple supervisors can be a notable cause for student dissatisfaction with clinical experiences (Sundler et al., 2014).

An important yet under explored aspect of clinical placement is placement duration. Warne et al. (2010) identified a link between the duration of clinical placements and greater student satisfaction. In longer placements students can develop effective, individualised supervisory relationship and therapeutic relationships with patients. In relation to placement duration, Roxburgh (2014) questions how much time is required to develop the student—supervisor relationship, so that an informed assessment of the student can take place. Hellström-Hyson et al. (2012) argue that to fully understand contextual continuity in care delivery students need to spend sufficient time with patients using appropriate periods of reflection. The study findings, though inconclusive as to what an optimal duration may be, do suggest that placements could potentially be of insufficient duration to achieve satisfactory outcomes and effective student assessment.

4.3.3. *Opportunity for varied clinical education/supervision models*

Many of the studies in this review where students were able to directly report their experiences of 2 or more models of clinical

education, concluded the various models studied could offer differing advantages for students and/or the clinical settings (Croxon and Maginnis, 2009; Henderson et al., 2006a; Nash et al., 2009; Nishioka et al., 2014; Roxburgh, 2014; Walker et al., 2013). Croxon and Maginnis (2009) found both preceptorship and cluster models both supported 'hands on' practice and developed student confidence. The Clinical Teaching Associate model promoted opportunities for patient communication and skill acquisition, with the traditional model linking theory to practice. The students in Roxburgh's (2014) study proposed a hybrid model: Hub and Spoke placements in year one and three and traditional model in year two.

A mix of junior and senior students in Nishioka et al.'s (2014) study were surveyed repeatedly over the duration of their study program and the findings identified that students' learning, developmental and support needs varied over time. Hence, traditional models may benefit beginning students to develop discrete skills under clinical facilitator guidance (Nishioka et al., 2014). In contrast, focussing on the transition into practice, Nash et al. (2009) found that the final year students in their study wanted to experience reality, rostered shifts, patient load and time management afforded in collaborative models. Nishioka et al. (2014) found DEU students describe learning 'nursing' as opposed to the perceived skill development focus of traditional models. Consideration of clinical settings is also required, as areas with limited capacity to host students, may find preceptorship style models most practical to implement (Henderson et al., 2006c). Omer et al. (2013) suggests differing models can co-exist; however, students need adequate preparation to be receptive to the benefits each offer.

Though a mixed clinical education model may be challenging to integrate into an overall program of nursing study such an approach may address individual learning styles, the needs of differing clinical areas and support student progression over time to achieve requisite outcomes. Smyer et al. (2015) compared academic outcome in students experiencing dedicated education unit (DEU) instead of a traditional model placement. Whilst no significant differences were found, they concede that as students only experienced a DEU once, there may not have been sufficient exposure to generate an effect so students were neither advantaged nor disadvantaged. Nash et al.'s (2009) also found no significant difference in the models in their study but noted students electing to participate in an enhanced final transition placement where those more likely to access potentially enriching experiences. Individual preferred learning styles therefore require consideration when considering the outcomes in relation to preferred education models.

4.3.4. Ensuring viability

This theme considers whether a clinical education or supervision model can be implemented and supported as intended. This is illustrated by Walker et al. (2013) where the viability of a preceptorship model's 1:1, RN:student relationship can be undermined by staff shortages and busyness of the clinical unit, resulting in students having multiple preceptors. Similarly, Croxon and Maginnis (2009) found preference for their new cluster model, however, staff shortages and workload issues had prevented the pre-existing preceptor model's functional viability. Hence no matter how innovative and well received a new model may be initially evaluation over time becomes critical.

The willingness to embrace a new model is another issue. Nishioka et al. (2014) had ward personnel volunteer their wards for the new DEU format and suggest positive outcomes may not have been achieved if sites were involuntarily assigned the new model. Finally, students, supervisors and others must be adequately oriented and resourced to engage, as intended, to promote the viability of any model (Omer et al., 2013). This review focused on student perceptions which may be less sensitive to the logistics of implementation or viability, hence the views of clinical staff, academics and administrators would further inform future research.

5. Discussion

The papers reviewed exemplify the diversity inherent within the clinically based component of undergraduate nurse education. This inherent variation creates challenges in studying this area, both within local and across international boundaries. As there is increasing emphasis on interprofessional education, defining nursing models and having an agreed taxonomy is important. The countries represented and the scope of inquiry is testament to worldwide interest in identifying effective approaches within clinical education and evaluating the impact of innovations. This review found that regardless of the model of clinical education or supervision there are factors which transcend the 'models' and contextual constraints. These were the centrality of professional relationships, need for consistency and continuity in clinical education delivery, the opportunity for varied clinical education/supervision models and ensuring the viability of the model to function as designed. These themes indicate that all models have favourable attributes that can promote learning in the clinical setting and which can promote effective implementation of existing models and design of novel models in the future.

The importance of relationships has been found in other studies, for example the pivotal role of the supervisory relationship for student satisfaction (Courtney-Pratt et al., 2012; Warne et al., 2010). Positive relationships promote student engagement, generate sufficient challenge for learning to occur and support constructive feedback (Grealish and Ranse, 2009). The notion of relationship extends to students having sufficient time to develop therapeutic interactions and shift from seeing a *patient and diagnosis*, through to understanding the *person* (James and Chapman, 2009). Several studies consider longer placements providing time for relationships to build, and create opportunities for students to integrate and contribute to the team resulting in greater satisfaction (Walker et al., 2013; Warne et al., 2010). Further, longer placements allow the student-supervisor relationship to develop sufficiently to offer an insightful and robust student assessment (Roxburgh, 2014).

Whilst the student voice is dominant, the review has considerations for those charged with the design and governance of clinical education. There is scope for different models and approaches dependant on the clinical setting, individual needs of students, requirements over the program of study and to facilitate students experiences of nursing within the broader health care context. In Chesser-Smyth's (2005) study, the first year students equated nursing with 'doing' and skill acquisition and this review found this supported by traditional models. Whereas, models such as preceptorship (Henderson et al., 2006c) or student wards (Hellström-Hyson et al., 2012) promote independence, offering options to address the concern that final year students may lack preparation for the real world workplace (Allan et al., 2011). Roxburgh (2014) found students have insight into the evolution of their needs across time and what different models offer. Utilising a variety of models may support increased diversification and offer less traditional settings, community or primary health, ways to support students (Smith et al., 2013).

The success of any particular model depends on its reliability, validity, viability and sustainability. Hence, understanding elements in any model that drive success, such as adequately prepared supervisors or placement duration, may be key. There is value in exploring models of clinical education as a whole, but scope to

examine specific components and identify what is effective and why, across models.

5.1. Limitations in this review

This review was restricted by specifically seeking studies evaluating more than one model of clinical education/supervision. Limiting the review to papers published in English, excludes insights from papers in other languages. The diversity in methods, and range of what, where and whom was studied in included papers, means the data cannot be aggregated or synthesized in a standard form. However, the four emergent themes have a level of generalizability within local contextual constraints.

Finally, the review selectively looked at students' perceptions and experiences and other stakeholder's views are not represented. The views of staff, supervisors and mentors may yield contrasting views, worthy of further exploration.

6. Conclusion

Implementation of the clinical curriculum is a critical yet challenging area of inquiry particularly in the contested environment of contemporary health care, making it a fruitful area of exploration and study. This integrative review sought to compare overarching models of undergraduate clinical education and rather than a single model being given preference over others, core elements emerged, that were common across multiple models.

There is scope to ask targeted questions, regardless of model, to further explore the nuances that impact student experiences of clinical education and acquisition of competencies. Establishing a consistent set of terms and definitions related to clinical education and student supervision will enhance the ability to explore differing models.

Seeking the best elements from many models of clinical education or approaches taken to student supervision will illuminate principles of best practice that can be applied across the diverse contexts of undergraduate clinical education and will continue to be an area for further research.

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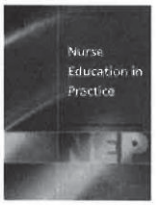

Title: In pursuit of an optimal model of undergraduate nurse clinical education: An integrative review

Author: Jan Forber,Michelle DiGiacomo,Bernie Carter,Patricia Davidson,Jane Phillips,Debra Jackson

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Appendix 2: Invitations to participate

All invitations to participate were sent via email and / or posted on intranet sites. This was initiated, at both sites, by the appropriate third party for example the student administration unit or research support unit.

Invitation: Site 1 Staff

TITLE: Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches

I am contacting you to invite you to participate in a research study exploring staff and students experiences of clinical 'placements'. My name is Jan Forber, and I am conducting this study as part of my full time Doctor of Philosophy course, at the University of Technology, Sydney.

I have asked you to participate because I am interested in the perceptions and experiences of staff who are engaged in any way with in the provision and support of undergraduate student's clinical learning experiences (or clinical placements). The aim of this research is to better understand what, for you, contributes to effective and positive clinical learning experiences and we are also interested in your ideas and suggestions for approaches to undergraduate nurse clinical education in the future.

Participation in the research would involve either attending a nominal group technique workshop, or if you are unable to attend a workshop, participating in a one-to-one interview. Participation in the nominal group technique workshop would be 60-90 minutes of time or an interview 45-60 minutes. If you are interested in participating a Participant Information Sheet is attached to this email which provides further information.

I hope you will feel able to take this opportunity to share your insightful perceptions and ideas and if you wish to participate in this study please reply to this email, providing an email contact or phone number. I will contact you to provide further information, workshop dates or to arrange an interview.

You are under no obligation to participate in this research.

Thank you for taking the time to consider this study.

Yours sincerely,

Jan Forber

Faculty of Health, UTS

Tel: 0402****** and email: Janet.Forber@student.uts.edu.au

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. 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 (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number (UTS HREC Ref No 2014000652). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Invitation: Site 1 Staff: amended to offer alternative participation option

TITLE: Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches < Insert: (UTS HREC 2014000652 & 2015000344).

Re: Alternative participation option

I'd like to sincerely thank everyone who has already participated in this research study. This email is a final invitation to anyone who has yet to participate but would like to do so and offers the option to take part in an interview or an online survey.

My name is Jan Forber, and I am exploring staff and students experiences of clinical 'placements' as part of my full time Doctor of Philosophy course, at the University of Technology, Sydney. I am interested in the perceptions and experiences of staff who are engaged, in any role, with the Bachelor of Nursing program and the links to the provision and support of undergraduate student's clinical learning experiences (or clinical placements). The aim of this research is to better understand what, for you, promotes effective and positive clinical learning experiences and we are also interested in your ideas and suggestions for approaches to the clinical component of undergraduate nurse education in the future.

Participation in the research would involve either, participating in a one-to-one interview (face to face or by telephone) or completing an online questionnaire or attending a nominal group technique workshop. An interview would be expected to take 40-50 minutes and the survey approximately 30 minutes. Participation in the nominal group technique workshop would be 60-90 minutes. If you are interested in participating a Participant Information Sheet is attached to this email which provides further information.

I hope you will feel able to take this opportunity to share your insightful perceptions and ideas and if you wish to participate in this study please reply to this email, providing an email contact or phone number. I will contact you to arrange an interview time, send a link to the survey or provide workshop dates.

You are under no obligation to participate in this research.

Thank you for taking the time to consider this study.

Yours sincerely,

Jan Forber

Faculty of Health, UTS

Tel: 0402****** and email: Janet.Forber@student.uts.edu.au

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. 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 (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Invitation: Site 1 Students

TITLE: Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches.

Dear Student,

My name is Jan Forber and I am a PhD student in the Faculty of Health, University of Technology Sydney.

I am conducting research to explore student and staff experiences of clinical placements and would welcome your assistance. I have asked you to participate because as a student enrolled in a Bachelor of Nursing program you have valuable personal experiences of 'clinical placements' that can contribute to this study. The aim of this research is to better understand what, for you, contributes to effective and positive clinical learning experiences and we are interested in your ideas and suggestions for approaches to undergraduate nurse clinical education in the future.

Participating in the research will involve completing an anonymous, online questionnaire and all final year BN students are being asked to participate. It is expected that the questionnaire should take no more than 30-40 minutes of your time however, as some questions are open-ended, this may vary dependant on how much information you provide.

At the end of the questionnaire you will be asked if you are interested in further participation in this research and attend a group workshop. This is optional and only if you provide contact details, which will be collated separately to your questionnaire answers, will you receive further information about the workshops.

This research is being conducted for my full time Doctor of Philosophy studies.

If you are interested in participating, please read the Participant Information Sheet attached to this email. The online questionnaire can be accessed via the following link:

https://www.surveymonkey.com/<add link>

You are under no obligation to participate in this research.

Yours sincerely,

Jan Forber

Faculty of Health, UTS

Tel: 0402****** and email: Janet.Forber@student.uts.edu.au

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. 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 (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number (UTS HREC Ref No 2014000652). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Invitation Site 1 Student: Revised Reminder/Final Email Invitation.

TITLE: Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches.

Dear Student,

My name is Jan Forber and I am a PhD student in the Faculty of Health, University of Technology, and Sydney. The research study Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches is drawing to a close at UTS. There is still time to take part and we really would like to hear from you.

There are 2 options to participate:

Complete an anonymous, online or paper based questionnaire - expected to take approx. 20 minutes, but this may vary dependant on how much information you provide. These will be available with coffee vouchers throughout August, building 10, and level 6 – check local posters or announcements for details.

OR participate in a Nominal Group Technique discussion - these workshops will consist of approximately 6-10 students, last for 60 minutes and take place between August 10-21. Light refreshments or a light lunch will be provided - check local posters or announcements for details or email me at Janet.Forber@student.uts.edu.au or txt 0402 ******.

As a final year BN student you are in a unique position contribute to the future development of clinical learning experiences. Understanding your positive experiences and capturing your ideas and developments for placements will inform research and innovation in this area. We hope you consider participating in this research but you are under no obligation to participate.

This research is being conducted for my full time Doctor of Philosophy studies.

Participant Information Sheets are attached to this email.

Yours sincerely,

Jan Forber

Faculty of Health, UTS

Tel: 0402****** and email: Janet.Forber@student.uts.edu.au

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. 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 (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number (UTS HREC Ref No 2014000652). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Invitation: Site 2 Staff

Heading: Research Invitation - Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches

Dear Colleagues,

Please see the message below from Jan Forber, PhD candidate in the Faculty of Health, University of Technology Sydney. This an invitation to all UCLan staff engaged with the pre-registration nursing programmes, to participate in a research project into pre-registration/undergraduate nurse clinical education. Please read on for further information. Thank you.

TITLE: Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches

I am contacting you to invite you to participate in a research study exploring staff and students experiences of clinical 'placements'. My name is Jan Forber, and I am conducting this study as part of my full time Doctor of Philosophy course, at the University of Technology Sydney. My supervisor at UCLan is Prof Bernie Carter.

I have asked you to participate because I am interested in the perceptions and experiences of staff who are engaged in any way with in the provision and support of pre-registration or undergraduate nursing student's clinical learning experiences (or clinical placements). The aim of this research is to better understand positive clinical learning experiences and also to explore your ideas and suggestions to what contributes to effective and promote innovative approaches to pre-registration nurse clinical education in the future.

Participation in the research would involve either participating in a face to face or telephone interview or attending a nominal group technique workshop. Participation in the nominal group technique workshop would be for 60 minutes of time or an interview estimated at 45 minutes although it could be conducted in a shorter space of time if that is more convenient to you. A Participant Information Sheet is attached to this message which provides further information.

If you would be willing to participate in this study please use the phone or email details below, to provide an email contact or phone number and I will contact you to provide further information, workshop dates or to arrange an interview.

You are under no obligation to participate in this research.

Thank you for taking the time to consider this study.

Yours sincerely,

Jan Forber

Faculty of Health, UTS

Tel: 07517 *** *** and email: jforber1@uclan.ac.uk OR Janet.Forber@student.uts.edu.au

NOTE: This study has been approved by the University of Central Lancashire, STEMH Research Ethics Committee. 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 Research Ethics Officer at roffice@uclan.ac.uk and quote this number STEMH 378.

Invitation: Site 2 Students

TITLE: Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches.

Dear Student,

My name is Jan Forber and I am a PhD student in the Faculty of Health, University of Technology, and Sydney, Australia. My supervisor at UCLan is Prof Bernie Carter from the School of Health.

I am conducting research to explore student and staff experiences of clinical placements and would welcome your assistance. I have asked you to participate because as a student enrolled in a pre-registration nursing program you have valuable personal experiences of 'clinical placements' that can contribute to this study. The aim of this research is to better understand what contributes to effective and positive clinical learning experiences and we are interested in your ideas and suggestions for innovative approaches to pre-registration nurse clinical education in the future.

Participating in the research will involve completing an anonymous questionnaire either on-line or paper copy. All final year nursing students are being asked to participate. It is expected that the questionnaire should take no more than 20 minutes of your time. However, this may vary dependant on how much information you provide.

At the end of the questionnaire you will be asked if you are interested in further participation in this research and if you would like to attend a group workshop. This is optional and only if you provide contact details, which will be collated separately to your questionnaire answers, will you receive further information about the workshops.

If you are interested in participating I will be distributing the link to the survey and paper copies on campus during September via lectures or classes.

You are under no obligation to participate in this research.

This research is being conducted for my full time Doctor of Philosophy studies.

Yours sincerely,

Jan Forber

Faculty of Health, UTS

Tel: 0751 ****** email: Jforber1@uclan.ac.uk or Janet.Forber@student.uts.edu.au

NOTE: This study has been approved by the University of Central Lancashire, STEMH Research Ethics Committee. 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 Research Ethics Officer at roffice@uclan.ac.uk and quote this number STEMH 378.

Appendix 3: Participant information sheets

Participant information sheet: Site 1 Staff

INFORMATION SHEET: University Staff

Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches (UTS HREC REF NO. 2014000652)

WHO IS DOING THE RESEARCH?

My name is Jan Forber, and I am a PhD student in the Faculty of Health, UTS. My principle supervisor is Dr Michelle DiGiacomo, Faculty of Health, UTS.

WHAT IS THIS RESEARCH ABOUT?

This research aims to find out more about what 'works well' in relation to undergraduate nursing clinical placements and to seek innovative and novel ideas from those involved with or experiencing nurse education, as to how nurse clinical education ('placements') could be delivered in the future.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to take part in either a nominal group technique (NGT) workshop or an individual interview. The workshops will be held on campus and last for 60-90 minutes and light refreshments will be provided. Alternatively you can participate in an individual interview, either face-to-face or via telephone. The interview would be arranged at a convenient time and place. The interview will last 45-60 minutes. Both the workshops and interviews will be audio recorded.

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there is some risk/inconvenience. There is the inconvenience of the time required to participate in the NGT workshop OR individual interview. There may also be some self-consciousness associated as the workshops and interviews will be audio recorded. Whilst considered unlikely, should you recall negative or challenging experiences you have had with clinical placements relevant contact information can be provided to review this with you.

With regard to your confidentiality and privacy, information which could identify you will be removed from any submissions for presentation or publication. The data you provide will be kept confidential.

WHY HAVE I BEEN ASKED?

You have been invited because, as a member of staff involved with undergraduate nurse education, your valuable personal experiences, for example in, preparing students for clinical placements, supporting the provision of clinical placements, or developing clinical curricula, can contribute to this study.

DO I HAVE TO SAY YES?

You do not have to say yes. Participation in this research is voluntary. Whether you decide to take part, not take part or withdraw from the study will not affect any aspect of your role or relationship with UTS.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me on *+61 0402****** or email Janet.Forber@student.uts.edu.au* or contact my supervisor Dr Michelle DiGiacomo - email Michelle.DiGiacomo@uts.edu.au

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772, and quote this number UTS HREC REF NO. 2014000652.

Participant information sheet: Site 1 Staff Amended

INFORMATION SHEET: University Staff

Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches (UTS HREC REF NO. 2014000652 & 2015000344)

WHO IS DOING THE RESEARCH?

My name is Jan Forber, and I am a PhD student in the Faculty of Health, UTS. My principle supervisor is Dr Michelle DiGiacomo, Faculty of Health, UTS

WHAT IS THIS RESEARCH ABOUT?

This research aims to find out more about what 'works well' in relation to undergraduate nursing clinical placements and to seek innovative and novel ideas from those involved with or experiencing nurse education, as to how nurse clinical education ('placements') could be delivered in the future.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to take part in either an individual interview, complete an online questionnaire or nominal group technique (NGT) workshop. An individual interview, either face-to-face or via telephone, can be arranged at a convenient time and place. The interview will last 40-50 minutes. The online survey can be completed at any time and takes an estimated 30mins. Workshops will be held on campus and last for 60-90 minutes and light refreshments will be provided. The interviews or workshops will be audio recorded.

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there is some risk/inconvenience. There is the inconvenience of the time required to participate in an interview, a NGT workshop or complete the survey. There may also be some self-consciousness associated as the workshops and interviews will be audio recorded. Whilst considered unlikely, should you recall negative or challenging experiences you have had with clinical placements relevant contact information can be provided to review this with you.

With regard to your confidentiality and privacy, information which could identify you will be removed from any submissions for presentation or publication. The data you provide will be kept confidential.

WHY HAVE I BEEN ASKED?

You have been invited because, as a member of staff involved with undergraduate nurse education, your valuable personal experiences, for example in, preparing students for clinical placements, supporting the provision of clinical placements, or developing clinical curricula, can contribute to this study.

DO I HAVE TO SAY YES?

You do not have to say yes. Participation in this research is voluntary. Whether you decide to take part, not take part or withdraw from the study will not affect any aspect of your role or relationship with UTS.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me on *+61 0402****** or email Janet.Forber@student.uts.edu.au* or contact my supervisor Dr Michelle DiGiacomo - email Michelle.DiGiacomo@uts.edu.au

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772, and quote this number UTS HREC REF NO. 2014000652 & 2015000344 .

Participant information sheet: Site 1 Students

INFORMATION SHEET: Students - Online Questionnaire

Undergraduate Nurse Clinical Education: An appreciative dialogue to explore innovative approaches.

(UTS HREC REF NO. 2014000652)

My name is Jan Forber, and I am a PhD student in the Faculty of Health, UTS. My principle supervisor is Dr Michelle DiGiacomo, Faculty of Health, UTS

The purpose of this research and online questionnaire is to find out about what 'works well' in relation to nursing students clinical placements and to explore innovative and novel ideas from students as to how nurse clinical education ('placements') could be delivered in the future.

All final year BN students are being invited to complete an anonymous online questionnaire. The questionnaire will ask about your positive experiences of clinical placements and your ideas/ suggestions for future improvements or innovations for clinical learning experiences. At the start of the questionnaire you will be asked to indicate your consent to take part in the project. You will then proceed to the questionnaire which is expected to take 30-40 minutes of your time.

You can complete ONLY the questionnaire and end your participation in the research at this point. However, at the end of the questionnaire you will have the option to indicate if you are interested in attending a nominal group technique workshop and to provide your contact details. Your contact details will be collated separately to the questionnaire so that your responses cannot be identified as belonging to you. Workshops will take place at the City campus on several dates/times to accommodate participant's preferences.

You can change your mind at any time and stop completing the questionnaire without any consequences. Whether you decide to take part, not take part, this will not affect any aspect of your studies at UTS, and will not have any impact on your assessment or grades.

If you agree to be part of the research and to research data gathered from this survey to be published in a form that does not identify you, please access the questionnaire via this link**:**

https://www.surveymonkey.com/s/AI_Clinical_2015

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me on *+61 0402****** or email Janet.Forber@student.uts.edu.au* or my supervisor Dr Michelle DiGiacomo - email Michelle.DiGiacomo@uts.edu.au

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772, and quote this number UTS HREC REF NO. 2014000652.

Thank you for taking the time to consider this study.

Jan Forber

Participant information sheet: Site 2 - Staff

INFORMATION SHEET: University Staff

Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches (UCLan REF NO STEMH 378)

WHO IS DOING THE RESEARCH?

My name is Jan Forber, and I am a PhD student in the Faculty of Health, University of Technology (UTS) Sydney, Australia. My principle supervisor is Dr Michelle DiGiacomo, Faculty of Health, UTS and Prof. Bernie Carter, one of my co-supervisors is Professor of Children's Nursing, University of Central Lancashire.

WHAT IS THIS RESEARCH ABOUT?

This research aims to find out more about what 'works well' in relation to pre-registration nursing clinical education/placements and to seek your innovative and novel ideas, as to how clinical education ('placements') could be enhanced and delivered in the future.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to take part in either an individual interview or nominal group technique (NGT) workshop. An individual interview, either face-to-face or via telephone, can be arranged at a convenient time and place. The interview will last about 45 minutes; although it could be conducted in a shorter space of time if that is more convenient to you. NGT Workshops will be held on campus and last for about 60 minutes and light refreshments will be provided. The interviews or workshops will be audio recorded.

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there are some risks/inconveniences. There is the inconvenience of the time required to participate in an interview or a NGT workshop. You may feel a bit self-conscious as, with your permission, the workshops and interviews will be audio recorded. You need to be aware that things you share in the workshop will be heard by other people in the workshop. You will be asked to agree not to share information you have heard as part of the workshop outside of the workshop. Whilst considered unlikely, should you recall negative or challenging experiences you have had with clinical experiences/placements relevant contact information can be provided to review this with you.

With regard to your confidentiality and privacy, information which could identify you will be removed from all submissions for presentation or publication. The data you provide will be kept confidential.

WHY HAVE I BEEN ASKED?

You have been invited because, as a member of staff involved with pre-registration nurse education, your valuable personal experiences, for example in, preparing students for clinical experiences/placements, supporting the provision of clinical experiences/placements, or developing clinical curricula, can contribute to this study.

DO I HAVE TO SAY YES?

You do not have to say yes. Participation in this research is totally voluntary. Whether you decide to take part, not take part or subsequently withdraw from the study will not affect any aspect of your role or relationship with UCLan.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact further about this research. Please disregard any future reminders.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. Interview participation can be withdrawn however as the Nominal Group Workshops are group activities it may not be possible to withdraw your contribution in its entirety.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me on 07517 *** *** or email jforber1@uclan.ac.uk OR Janet.Forber@student.uts.edu.au or contact my supervisors Dr Michelle DiGiacomo - email Michelle.DiGiacomo@uts.edu.au or Prof. Bernie Carter – email bcarter@uclan.ac.uk

If your concern is not resolved to your satisfaction, please contact the University Officer for Ethics at OfficerForEthics@ulcan.ac.uk and quote this number STEMH 378

Participant information sheet Site 2 Students

INFORMATION SHEET: Students - Questionnaire

Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches (UCLan STEMH 378)

WHO IS DOING THE RESEARCH?

My name is Jan Forber, and I am a PhD student in the Faculty of Health, University of Technology Sydney, Australia. My principle supervisor is Dr Michelle DiGiacomo, Faculty of Health, UTS and Prof. Bernie Carter, one of my co-supervisors is Professor of Children's Nursing, University of Central Lancashire.

WHAT IS THIS RESEARCH ABOUT?

The purpose of this research and questionnaire is to find out about what 'works well' in relation to nursing students clinical placements and to explore innovative and novel ideas from students as to how nurse clinical education ('placements') could be delivered in the future.

IF I SAY YES, WHAT WILL IT INVOLVE?

All final year pre-registration are being invited to complete an anonymous questionnaire, which can be accessed either on-line or as a paper version. The questionnaire will ask about your positive experiences of clinical placements and your ideas/ suggestions for future improvements or innovations for clinical learning experiences. At the start of the questionnaire you will be asked to indicate your consent to take part in the research. If you consent, you will then proceed to the questionnaire which is expected to take about 20 minutes of your time.

You can complete ONLY the questionnaire and end your participation in the research at this point. However, at the end of the questionnaire you will have the option to indicate if you are interested in further participation and attending a nominal group technique (NGT) workshop. If you provide your contact details these will be collated separately to the questionnaire so that your responses cannot be identified as belonging to you. Workshops will take place on campus on several dates/times to accommodate participant's preferences. Expressing interest in the workshop, on completing the questionnaire, is not a commitment to attend and not everyone who indicates an interest in NGT participation will necessarily be invited to participate, as workshops have a maximum number of participants.

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there is some risk/inconvenience. There is the inconvenience of the time required to complete the questionnaire. Whilst this research asks about positive experiences you may have feedback about negative or challenging experiences you have had with clinical placements. If this arises information will be available and provided as to where to obtain further assistance and support. With regard to your confidentiality and privacy, information which could identify you will be removed from any submissions made for presentation or publication and the data you provide will be kept confidential.

WHY HAVE I BEEN ASKED?

You have been invited because; as a student enrolled in a pre-registration nursing program you have valuable personal experiences of 'clinical placements' that can contribute to this study.

DO I HAVE TO SAY YES?

You do not have to say yes. Participation in this research is voluntary. Whether you decide to take part, not take part or withdraw from the study will not affect any aspect of your studies at UCLan, and will not have any impact on your assessment or grades.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again. Please disregard any future reminders

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. You can withdraw from the study or stop completing the questionnaire at any time without any consequences. However, as this is an anonymous questionnaire, once submitted the responses cannot be withdrawn as the data cannot be linked back to you.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact me on 07517 ******, Jforber1@uclan.ac.uk or or Janet.Forber@student.uts.edu.au or my supervisors Dr Michelle DiGiacomo - email Michelle.DiGiacomo@uts.edu.au or Prof Bernie Carter at bcarter@uclan.ac.uk

If your concern is not resolved to your satisfaction, please contact the University Officer for Ethics at OfficerForEthics@ulcan.ac.uk and quote this number STEMH 378.

Thank you for taking the time to consider this study.

Appendix 4: Examples of promotional posters – Students Site 1 and 2

Be part of the conversation

ALL FINAL YEAR BN STUDENTS - *We want you....*

The research study ***Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches*** **is drawing to a close at UTS.** There is still time to take part and we want to hear from you. As current final year students, you are in a unique position contribute to the future development of clinical learning experiences. Understanding your positive experiences and capturing innovative ideas for placements will inform research in this area.

You can complete a questionnaire, over coffee (vouchers provided) either online or paper copies will be made available throughout August.

All participation is voluntary and the questionnaire should take 20 minutes to complete.

Alternatively if you would prefer, come along and take part in a Nominal Group Technique discussion with lunch or light refreshments provided. These will run on:

<insert dates>

If you are interested in participating, via survey or in a discussion group, please email Janet.Forber@student.uts.edu.au or send a txt 0402 670741 for further details and to confirm times and venue details.

My name is Jan Forber and I am undertaking this research as part of PhD studies in the Faculty of Health, University of Technology, Sydney. I can be contacted on 0402670741 or email janet.forber@student.uts.edu.au

You are under no obligation to participate in this research. Thank you!

Be part of the conversation

ALL FINAL YEAR NURSING STUDENTS - *We want you....*

The research study ***Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches*** is taking place at UCLan and we really would like to hear from you. As current final year students, you are in a unique position to contribute to the future development of clinical learning experiences. Understanding your positive experiences and capturing your innovative ideas for placements will inform research in this area.

You can complete a questionnaire either online OR paper copies will be made available throughout September - watch out for email reminders and notices.

All participation is voluntary. The questionnaire should take 20 minutes to complete.

Alternatively, come along and take part in a Nominal Group Technique group discussion with lunch or light refreshments provided. These will run in the weeks of:

28th Sept and 5th October 2015

If you are interested in participating in a group discussion, please email <insert> or send a sms with your contact email to 07517 ****** for further details and to confirm times and venue details.

My name is Jan Forber and I am undertaking this research as part of PhD studies in the Faculty of Health, University of Technology, Sydney. I can be contacted on 07517 ****** or email <insert>

You are under no obligation to participate in this research. Thank you!

Appendix 5: Consent forms

Site 1 Consent Form: Site 1 - Staff Semi-Structured Interview

CONSENT FORM: Semi-structured Interview

For use in conjunction with Information Sheet: University Staff Semi Structured Interview

I _____ agree to participate in the research project *Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches* (UTS HREC REF NO. 2014000652) being conducted by Jan Forber, Faculty of Health, University of Technology, Sydney, P.O. Box 123, Broadway, NSW 2007, tel: 0402 *** *** for her degree Doctor of Philosophy (Nursing). Funding for this research has been provided by an Australian Postgraduate Scholarship.

I understand that the purpose of this study is to explore the strengths or 'what works well' in undergraduate nurse clinical education and to consider views and innovative ideas as to how nurse clinical education ('placements') could be delivered in the future.

I understand that I have been asked to participate in this research because of my experience and expertise in undergraduate nurse education and that my participation in this research will involve taking part in an individual semi-structured interview. The estimated time commitment is 45-60 minutes. The risks in taking part are the inconvenience of taking time to participate and possible self-consciousness in the interview being audio recorded. Interviews will take place on campus and at a time convenient agreed by me. Should my participation in the study raise any concerns about negative or challenging experiences I have had with clinical placements I am aware that relevant contact information can be provided for further support.

I am aware that any Information which could identify me will be removed from any submissions made for presentation or publication and the data I provide will be kept confidential.

I am aware that I can contact Jan Forber or her supervisor Dr Michelle DiGiacomo if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason and this will not prejudice my future employment or relationship with UTS.

I agree that Jan Forber has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____

Signature (participant)

_____ _____/____/____

Signature (researcher or delegate)

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. 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 (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Consent Form: Site 2 - Staff Semi-Structured Interview

CONSENT FORM: Semi-structured Interview

For use in conjunction with Information Sheet: University Staff Semi Structured Interview

I _____ agree to participate in the research project Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches (UCLan STEMH NO. 378) being conducted by Jan Forber from the Faculty of Health, University of Technology, Sydney, P.O. Box 123, Broadway, NSW 2007, tel: 07517 ****** for her degree Doctor of Philosophy (Nursing). Funding for this research has been provided by an Australian Postgraduate Scholarship.

I understand that the purpose of this study is to explore the strengths or 'what works well' in undergraduate nurse clinical education and to consider views and innovative ideas as to how nurse clinical education ('placements') could be delivered in the future.

I understand that I have been asked to participate in this research because of my experience and expertise in undergraduate nurse education and that my participation in this research will involve taking part in an individual semi-structured interview. The estimated time commitment is 45-60 minutes. The risks in taking part are the inconvenience of taking time to participate and possible self-consciousness in the interview being audio recorded. Interviews will take place on campus and at a time convenient agreed by me. Should my participation in the study raise any concerns about negative or challenging experiences I have had with clinical placements I am aware that relevant contact information can be provided for further support.

I am aware that any Information which could identify me will be removed from any submissions made for presentation or publication and the data I provide will be kept confidential.

I am aware that I can contact Jan Forber or her supervisor Dr Michelle DiGiacomo if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without

I agree that Jan Forber has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____

Signature (participant)

_____ _____/____/____

Signature (researcher or delegate)

NOTE: This study has been approved by the University of Central Lancashire STEMH Research Ethics Committee. 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 Research and Innovation Office at roffice@uclan.ac.uk and quote the Ref. No. STEMH 378.

Appendix 6: Online Questionnaires

The online and paper based version of the questionnaires contained the same questions.

Online-Questionnaire: Site 1 Students

INTRODUCTION AND CONSENT

Thank you for logging into this online questionnaire for the research study Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches. The purpose of this questionnaire is to find out about your positive experiences of clinical placements and get your ideas and recommendations for the future. Further information is available in the Participant Information Sheet, provided with the invitation to participate in the study.

This study is based on an approach called Appreciative Inquiry, a way of researching that focuses on the positive, seeking out the 'best' or 'what works', rather than focusing on problems. Identifying the successes and strengths in clinical education can guide how we develop and improve in the future. As a student, your experiences are a particularly valuable source of information and I hope you are able to give 30-40 minutes of your time to complete the questionnaire. As some questions are open-ended, the exact time to complete the questionnaire may vary dependant on how much information you provide.

Consent to participate

Please read the following statements and if you consent to participate in the research please click below to proceed to the questionnaire:
1. I agree to participate in the study described in the participant information sheet provided.
2. I acknowledge that I have read the participant information sheet, which explains why I have been selected, the aims of the study and the nature and the possible risks of the study, and the research has been explained to me to my satisfaction.
3. I understand that I can withdraw from the study or exit the questionnaire at any time without any consequences. However, as this is an anonymous questionnaire, once submitted the responses cannot be withdrawn as the data cannot be linked back to me.
4. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

If you have any questions related to this study or any problems in completing the questionnaire please feel free to contact me via email Janet.Forber@student.uts.edu.au or phone 0402 670 741. Alternatively you can contact my academic supervisor, Dr Michelle DiGiacomo at Michelle.DiGiacomo@uts.edu.au

I understand and consent to participate in this anonymous online questionnaire. Please click <NEXT> to continue to the questionnaire.

HOW TO COMPLETE THIS QUESTIONNAIRE

This questionnaire has 4 sections. You can move backwards and forwards through the questions using the PREV and NEXT buttons at the bottom of the page. If you exit a partially completed questionnaire you will not be able to return to those responses. For some questions, space has been provided for you to write your answers. Answers can be written in sentence format, bullet point, or note form. Whilst there are no right or wrong answers - but we would like to hear about good or positive experiences so we can better understand what this means for you.

We ask that you avoid identifying any facilities or people by not using real names. As an example you could describe a supervisor as the Ward RN or the Clinical Facilitator. With facilities use descriptors such as, an aged care facility or a cardiology ward.

Section 1: How much clinical time would you like there to be?

1. What do you value the most about clinical learning experiences?

2. In your BN Program as a whole, would you like there to be more, about the same or less time spent on clinical ?

A lot more	A little more	About the same	A little less	A lot less
○	○	○	○	○

Briefly, please say why you chose this option

3. If a typical placement is 2 weeks or 10 shifts in duration, how long would you prefer the placement to be ?

A lot longer	A little longer	The same	A little shorter	A lot shorter
○	○	○	○	○

Briefly, please say why you chose this option

4. What do you think is an ideal length for a clinical placement?

Number of weeks

and number of shifts in each week

5. Which of the following shifts have you experienced in your BN program so far?

- [ ] AM or morning
- [ ] PM or afternoon/evening
- [ ] Weekends
- [ ] Night duty
- [ ] other, please specify

Other (please specify)

6. If you could choose, would you prefer a block placement - with 5 shifts per week for a set number of weeks OR a continuous placement with, for example, 2 days of clinical per week spread over the semester

- [ ] Block Placement
- [ ] Continuous Placement
- [ ] Some of each
- [ ] The option to choose

Other (please specify)

7. Do you feel there is anything unique that only real life clinical experiencess can give you within the BN program?

Section 2: In your experience what 'works well'…

For the questions in this section, think of the best clinical learning experience you have had in your undergraduate program. This may be a time when you have felt most engaged, most excited, most able to learn or when it just 'worked well'. The experience could be an entire placement, a group of shifts or a particular day.

8. When thinking of this 'best' clinical experience, why does this placement or experience stand out for you - what was it about you, other people, the arrangement, the setting or anything else that made this the best.

9. Where did this experience take place – for example was it a hospital ward, community centre, nursing home etc.

10. What was the area of nursing practice, such as cardiology, community, child or mental health?

11. Was this experience the entire placement, a group of shifts, a particular day or other situation?

12. How long was the placement during which this experience took place?

13. In which year and semester of your BN program did this experience occur?

Section 3:If you were to design clinical experiences for future students ….

In this section we are seeking your positive ideas and suggestions as to what undergraduate nurse clinical education could be or would look like if you designed it. Your ideas do not need to be limited by any existing constraints that are present in undergraduate nurse clinical education. So consider, what possibilities exist that may not have not thought of yet and what could be done differently to enhance students learning and the student experience.
You can consider undergraduate clinical education in the BN program overall, or the concept of a 'placement' or it may be a specific aspect of clinical education.

14. If you were to design or develop the best undergraduate clinical learning experience(s), what do you think they would or could 'look' and 'be' like?

Section 3: Continued

For any or all of the following, please give one key POSITIVE change or suggestion you would make to enhance that aspect of undergraduate nurse clinical education.

15. To the way placements are organised?

16. To the way students are supported or supervised on clinical?

17. To support how students learn on clinical

18. To the way students are assessed?

19. To how students are prepared for their clinical experiences

Section 4: Finally we'd like to ask some questions about you...

20. Today, what is your age in years?

21. Are you male or female?

- Male
- Female

22. Are you enrolled in a standard entry 3 year BN program or an accelerated entry program

- Standard entry 3 year BN program
- Accelerated entry program

23. Are you an international or local student?

- International
- Local

24. Is English you first language?

- Yes
- No

25. In which country were you born?

26. BEFORE commencing the BN program did you have any experience as a nurse e.g. enrolled nurse, assistant in nursing, RN overseas? Please provide your role and duration of experience in months/years

27. In your current or most recent semester, on average how many hours a week did you spend in paid employment?

- ◯ 5 hours or less per week
- ◯ 6-10 hours per week
- ◯ 11-15 hours per week
- ◯ 16-20 hours per week
- ◯ 21-25 hours per week
- ◯ 26-30 hours per week
- ◯ 31 hours or more per week

28. Is your paid work healthcare related, non-healthcare related, a combination or other?

- ☐ Healthcare related
- ☐ Non-healthcare related
- ☐ A combination - some hlearhcare work and some non-health related work
- ☐ Other

If healthcare related please give our role

29. In your most recent clinical placement, on average how many hours a week did you spend in paid employment?

- ◯ 5 hours or less per week
- ◯ 6-10 hours per week
- ◯ 11-15 hours per week
- ◯ 16-20 hours per week
- ◯ 21-25 hours per week
- ◯ 26-30 hours per week
- ◯ 31 hours or more per week

END OF SURVEY

Thank you for taking the time to participate in this survey, your contribution is genuinely very much appreciated.

Nominal Group Technique Workshop Invitation

If you are interested in participating in a Nominal Group Technique workshop, a further phase of this study, please proceed to the next page to provide contact details. These contact details will be collated separate to your response to the questionnaire. You will be sent further information on the workshops and invited to participate. Expressing interest at this stage is not a commitment to attend a workshop

Nominal Group Technique Workshop - Contact details

Please provide the following details and you will be sent an email with further information regarding the Nominal Group Technique Workshops.

This information will be correlated separately to the questionnaire answers and not used to identify participants

30. Your full name

31. Your UTS student email address

Online-Questionnaire: Site 2 Students

INTRODUCTION AND CONSENT

Thank you for logging into this online questionnaire for the research study Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches. The purpose of this questionnaire is to find out about your positive experiences of clinical placements and get your ideas and recommendations for the future. Further information is available in the Participant Information Sheet, provided with the invitation to participate in the study.

This study is based on an approach called Appreciative Inquiry, a way of researching that focuses on the positive, seeking out the 'best' or 'what works', rather than focusing on problems. Identifying the successes and strengths in clinical education can guide how we develop and improve in the future. As a student, your experiences are a particularly valuable source of information and I hope you are able to give 20 minutes of your time to complete the questionnaire. As some questions are open-ended, the exact time to complete the questionnaire may vary dependant on how much information you provide.

Consent to participate

Please read the following statements and if you consent to participate in the research please click below to proceed to the questionnaire:
1. I agree to participate in the study described in the participant information sheet provided.
2. I acknowledge that I have read the participant information sheet, which explains why I have been selected, the aims of the study and the nature and the possible risks of the study, and the research has been explained to me to my satisfaction.
3. I understand that I can withdraw from the study or exit the questionnaire at any time without any consequences. However, as this is an anonymous questionnaire, once submitted the responses cannot be withdrawn as the data cannot be linked back to me.
4. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

If you have any questions related to this study or any problems in completing the questionnaire please feel free to contact me via email Janet.Forber@student.uts.edu.au. Alternatively you can contact my academic supervisors, Dr Michelle DiGiacomo at Michelle.DiGiacomo@uts.edu.au or Prof Bernie Carter at BCarter@uclan.ac.uk

I understand and consent to participate in this anonymous online questionnaire. Please click <NEXT> to continue to the questionnaire.

HOW TO COMPLETE THIS QUESTIONNAIRE

This questionnaire has 4 sections. You can move backwards and forwards through the questions using the PREV and NEXT buttons at the bottom of the page. If you exit a partially completed questionnaire you will not be able to return to those responses. For some questions, space has been provided for you to write your answers. Answers can be written in sentence format, bullet point, or note form. Whilst there are no right or wrong answers - but we would like to hear about good or positive experiences so we can better understand what this means for you.

We ask that you avoid identifying any facilities or people by not using real names. As an example you could describe a ward nurse, mentor or sign-off mentor. With facilities use descriptors such as, an aged care facility or a cardiology ward.

Section 1: How much clinical time would you like there to be?

1. What do you value the most about clinical learning experiences?

2. In your pre-registration program as a whole, would you like there to be more, about the same or less time spent on clinical ?

A lot more	A little more	About the same	A little less	A lot less
○	○	○	○	○

Briefly, please say why you chose this option

3. What do you think is an ideal length for a clinical placement?

Number of weeks

and number of shifts in each week

4. Which of the following shifts have you experienced in your nursing program so far?

- ☐ AM or morning
- ☐ PM or afternoon/evening
- ☐ Weekends
- ☐ Night duty
- ☐ other, please specify

Other (please specify)

5. If you could choose, would you prefer a block placement - with 5 shifts per week for a set number of weeks OR a continuous placement with, for example, 2 days of clinical per week spread over the year

- [ ] Block Placement
- [ ] Continuous Placement
- [ ] Some of each
- [ ] The option to choose

Other (please specify)

6. Do you feel there is anything unique that only real life clinical experiencess can give you within the pre-registration nursing program?

Section 2: In your experience what 'works well'…

For the questions in this section, think of the best clinical learning experience you have had in your undergraduate program. This may be a time when you have felt most engaged, most excited, most able to learn or when it just 'worked well'. The experience could be an entire placement, a group of shifts or a particular day.

8. When thinking of this 'best' clinical experience, why does this placement or experience stand out for you - what was it about you, other people, the arrangement, the setting or anything else that made this the best.

9. Where did this experience take place – for example was it a hospital ward, community centre, nursing home etc.

10. What was the area of nursing practice, such as cardiology, community, child or mental health?

11. Was this experience the entire placement, a group of shifts, a particular day or other situation?

12. How long was the placement during which this experience took place?

13. In which year and semester of your BN program did this experience occur?

Section 3:If you were to design clinical experiences for future students ….

In this section we are seeking your positive ideas and suggestions as to what pre-registration nurse clinical education could be or would look like if you planned or designed it. Your ideas do not need to be limited by any existing constraints that are present in nurse clinical education. So consider, what possibilities exist that may not have not thought of yet and what could be done differently to enhance students learning and the student experience.
You could consider pre-registration clinical education overall, or the concept of a 'placement' or it may be a specific aspect of clinical education.

14. If you were to design or develop the best clinical learning experience(s), what do you think they would or could 'look' and 'be' like?

Section 3: Continued

In this section you can answer all, some or none of the questions. Please give one key POSITIVE change or suggestion you would make to enhance that aspect of pre-registration nurse clinical education.

15. To the way placements are organised?

16. To the way students are supported or mentored on clinical?

17. To support how students learn on clinical

18. To the way students are assessed?

19. To how students are prepared for their clinical experiences

Section 4: Finally we'd like to ask some questions about you...

20. Today, what is your age in years?

21. Are you male or female?

- ◯ Male
- ◯ Female

22. Are you enrolled in a standard entry 3 year BN program or an accelerated entry program

- ◯ Standard entry 3 year BN program
- ◯ Accelerated entry program

23. Are you an international or local student?

- ◯ International
- ◯ Local

24. Is English you first language?

- ◯ Yes
- ◯ No

25. In which country were you born?

26. BEFORE commencing the BN program did you have any experience as a nurse e.g. enrolled nurse, assistant in nursing, RN overseas? Please provide your role and duration of experience in months/years

27. In your current or most recent term or semester, on average how many hours a week did you spend in paid employment?

- ◯ 5 hours or less per week
- ◯ 6-10 hours per week
- ◯ 11-15 hours per week
- ◯ 16-20 hours per week
- ◯ 21-25 hours per week
- ◯ 26-30 hours per week
- ◯ 31 hours or more per week

28. Is your paid work healthcare related, non-healthcare related, a combination or other?

- ☐ Healthcare related
- ☐ Non-healthcare related
- ☐ A combination - some healthcare work and some non-health related work
- ☐ Other

If healthcare related please give our role

29. In your most recent clinical placement, on average how many hours a week did you spend in paid employment?

- ◯ 5 hours or less per week
- ◯ 6-10 hours per week
- ◯ 11-15 hours per week
- ◯ 16-20 hours per week
- ◯ 21-25 hours per week
- ◯ 26-30 hours per week
- ◯ 31 hours or more per week

END OF SURVEY

Thank you for taking the time to participate in this survey, your contribution is genuinely very much appreciated.

Nominal Group Technique Workshop Invitation

If you are interested in participating in a Nominal Group Technique workshop, a further phase of this study, please provide contact details. These contact details will be collated separate to your response to the questionnaire. You will be sent further information on the workshops and invited to participate. Expressing interest at this stage is not a commitment to attend a workshop

30. Please give your name and UCLan email address

Online-Questionnaire: Site 1 Staff

Undergraduate nurse clinical education: An appreciative dialogue to

INTRODUCTION AND CONSENT

Thank you for logging into this online questionnaire for the research study Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches. The purpose of this questionnaire is to find out about your positive experiences of clinical focused components of the BN program and get your ideas and recommendations for the future. Further information is available in the Participant Information Sheet, provided with the invitation to participate in the study.

This study is based on an approach called Appreciative Inquiry, a way of researching that focuses on the positive, seeking out the 'best' or 'what works', rather than focusing on problems. Identifying the successes and strengths in clinical education can guide how we develop and improve in the future. Your experiences are a valuable source of information and I hope you are able to give approx. 30 minutes of your time to complete the questionnaire. As many questions are open-ended, the exact time to complete the questionnaire may vary dependant on how much information you provide.

Consent to participate

Please read the following statements and if you consent to participate in the research please click below to proceed to the questionnaire:
1. I agree to participate in the study described in the participant information sheet provided.
2. I acknowledge that I have read the participant information sheet, which explains why I have been selected, the aims of the study and the nature and the possible risks of the study, and the research has been explained to me to my satisfaction.
3. I understand that I can withdraw from the study or exit the questionnaire at any time without any consequences.
4. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

If you have any questions related to this study or any problems in completing the questionnaire please feel free to contact me via email Janet.Forber@student.uts.edu.au or phone 0402 670 741. Alternatively you can contact my academic supervisor, Dr Michelle DiGiacomo at Michelle.DiGiacomo@uts.edu.au

I understand and consent to participate in this online questionnaire. Please click <NEXT> to continue to the questionnaire.

HOW TO COMPLETE THIS QUESTIONNAIRE

This questionnaire has 4 sections. You can move backwards and forwards through the questions using the PREV and NEXT buttons at the bottom of the page. If you exit a partially completed questionnaire you will not be able to return to those responses. For some questions, space has been provided for you to write your answers. Answers can be written in sentence format, bullet point, or note form. Whilst there are no right or wrong answers - but we would like to hear about good or positive experiences so we can better understand what this means for you.

We ask that you avoid identifying any facilities or people by not using real names, and use role titles, type of facility or setting instead.

Section 1: First a few questions about you...

1. Please provide your name (Your responses will be de-identified prior to data analysis)

Page 1

Undergraduate nurse clinical education: An appreciative dialogue to

2. Please list your professional and/or academic qualifications

3. How many years experience in nursing do you have?

4. What is your current role(s) and how long have you been in this role?

5. Please describe your current role in undergraduate nurse education. For example lecturer, subject coordinator etc.

6. Are you male or female?

- ◯ Male
- ◯ Female

Section 2: How much clinical time would you like there to be?

Questions in this section relate to the purpose and provision of clinical placements

7. In the standard 3 year BN Program as a whole, do you think students should spend more, about the same or less time spent on clinical ?

A lot more	A little more	About the same	A little less	A lot less
◯	◯	◯	◯	◯

Briefly, please say why you chose this option

8. In the accelerated BN program do you think students should spend more, about the same or less time on clinical ?

A lot more	A little more	The same	A little less	A lot less
○	○	○	○	○

Please, briefly explain why you chose this option

9. Do you think clinical placements should be designed as block placements - with 5 shifts per week for a set number of weeks OR a continuous placement with, for example, 2 days of clinical per week spread over the semester

- ☐ Block Placement
- ☐ Continuous Placement
- ☐ Some of each
- ☐ The option to choose

Other (please specify)

10. Based on a typical block placement week having 40 hours of clinical time - do you think there is an ideal number of weeks/length for a clinical placement?

- ☐ Yes
- ☐ No

If YES please specify if NO please comment:

11. In your view, is there anything unique that clinical learning experiences offer students in the preparation for future practice as a registered nurse?

12. What are the key goals of clinical education experiences or clinical placements?

Undergraduate nurse clinical education: An appreciative dialogue to

Section 3: In your experience what 'works well'...

Questions in this section seek you views and experiences as to what works well for various aspects of clinical education

13. In your experience with the UTS Bachelor of Nursing Program what 'works well' in the current approach to undergraduate nurse clinical education and why?

14. In the overall approach to clinical education at UTS what do you feel are the positive features or strengths?

15. What factors do you feel contribute to the quality of clinical experiences for students?

16. In the BN program which aspects are effective in preparing students for their clinical learning experiences/placements?

17. What works well in the provision of leadership for undergraduate clinical education?

18. Please feel free to add anything else that from your experience 'works well' currently in undergraduate nurse clinical education

Section 4:If you were to design clinical experiences for future students .....

In this section we are seeking your positive ideas and suggestions as to what undergraduate nurse clinical education could be like if you designed it. Your ideas do not need to be limited by any existing constraints that are present in undergraduate nurse clinical education. So consider, what possibilities exist that may not have not thought of yet and what could be done differently to enhance student learning and experience and/or the clinical facilitators experience.

You can consider this as an overall design or concept for clinical education in a BN program overall, or how an individual 'placement' may be conceived and can relate to any aspect of clinical education.

Undergraduate nurse clinical education: An appreciative dialogue to

19. If you were to design or develop the best undergraduate clinical learning experience (s), what do you think they would or could 'look' and 'be' like?

20. How could teaching and learning be enhanced in the clinical setting?

Section 3: Continued

Please answer as many of the following as you choose, and give up to three key POSITIVE changes or suggestions you would make to enhance the particular aspect of undergraduate nurse clinical education.

21. Changes or suggestions as to the way placements are organised?

22. Changes or suggestions on the way students are supported or supervised on clinical?

23. How to best maximise learning opportunities in the clinical setting?

Undergraduate nurse clinical education: An appreciative dialogue to

24. How students are assessed?

25. How students are prepared for their clinical experiences

26. How clinical facilitators are supported and developed in the role?

27. How could leadership and /or governance for clinical education be enhanced in the future?

END OF SURVEY

Thank you for taking the time to participate in this survey, your contribution is genuinely very much appreciated.

Appendix 7: Semi-Structured Interview guide

Project Title: ***Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches***

Plan: Interview schedule:

Introduction, information and consent

a. Participant information sheet – provide via invite – clarify any questions
    i. Establish demographics – via Data Collection Form - Participant Information
b. Obtain written consent including recording
c. Outline the plan for the interview
d. Interview based on schedule below
e. Conclude, and thank you

Pre-Question: Briefly describe your current (+ previous) role/position and what role do you currently have with undergraduate nurse clinical education at UTS. What responsibilities do you have in regards to student placements? Can you describe the aspects of your role that give you the most satisfaction?

For the following questions - any aspect of clinical (in-situ) education is relevant – preparation, purpose, structure, roles and responsibilities, communication, learning environment, logistics, planning, supporting under achieving students.

Q: WHAT WORKS WELL

Key Questions:

In your experience or your role what works well in undergraduate/pre-registration nurse clinical education and why?

In the overall approach to clinical education in this facility/institution what do you feel are the positive features or strengths?

How would you describe a quality clinical learning experience? OR what are the elements that contribute to that quality or successful clinical experience?

What is effective in preparing students or staff for clinical learning experiences?

Supplementary Questions:

How do existing guidelines/policies/directives support your engagement in clinical education?

How do you identify learning opportunities?

Are you able to utilise the learning opportunities available?

Does the current clinical education/placement model support learning?

Additional questions for Clinical Facilitators Site 1: What is the most effective supervisory relationship you have experienced and why?

When have you felt most welcome into a ward/unit and what made this so?

What is effective in preparing you for clinical learning experiences?

What is effective in preparing you as a clinical supervisor?

Q: DREAM QUESTION

Key Questions:

If a miracle happened and you could have the 'best' undergraduate nurse clinical education all the time what would or could this 'look' like'?

What could clinical experiences/placements 'look' like?

Should there be more or less clinical time?

How could you provide a better learning environment?

What changes would enhance your role?

How do you see the leadership for undergraduate nurse education develop in the future?

Supplementary Questions:

What support or resources would you like to have?

What changes would make to promote the supervisor role?

How could students be better prepared to work with supervisors and/or nursing staff?

Are there any professional development opportunities that you would suggest to develop the supervisors/mentors role?

Who needs to engage in/provide leadership for undergraduate nurse clinical nurse education?

How could learning in the clinical setting be maximised?

How could clinical teaching be more effectively supported or facilitated?

How could you be better prepared for clinical experiences - which aspects could be enhanced?

How could or should we engage the patient in clinical education

To summarise/prioritise: If you could make 3 (or other number) key changes to the current provision of undergraduate nurse clinical education to improve or enhance future practice, what would they be?

Prompt: you may have an overriding idea/concept, or you can consider a specific aspect - preparation, purpose, structure, roles & responsibilities, communication, learning environment, logistics planning etc.

END MAIN QUESTIONS

One final observation: In your view/opinion what is the unique purpose that clinical experiences serve in preparing learners for future practice?

OR Can you tell me what you see are the goals of clinical education experiences or 'clinical placements'

Appendix 8: Ethics Site 1 University of Technology Sydney

HREC Approval Number 2014000652 and two subsequent approved amendments UTS HREC REF NO. 2015000415 & 2015000344.

HREC Approval Granted

R Research.Ethics@uts.edu.au Reply all |
Fri 28/11/2014, 4:51 PM
Debra.Jackson@uts.edu.au; Janet Forber; Research.Ethics@uts.edu.au

Dear Applicant

Thank you for your response to the Committee's comments for your project titled, "Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches.". Your response satisfactorily addresses the concerns and questions raised by the Committee who agreed that the application now meets the requirements of the NHMRC National Statement on Ethical Conduct in Human Research (2007). I am pleased to inform you that ethics approval is now granted.

Your approval number is UTS HREC REF NO. 2014000652
Your approval is valid five years from the date of this email.

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

You should consider this your official letter of approval. If you require a hardcopy please contact Research.Ethics@uts.edu.au.

To access this application, please follow the URLs below:
* if accessing within the UTS network: http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx
* if accessing outside of UTS network: https://remote.uts.edu.au , and click on "RMENet - ResearchMaster Enterprise" after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
T: (02) 9514 9772
F: (02) 9514 1244
E: Research.Ethics@uts.edu.au
I: http://www.research.uts.edu.au/policies/restricted/ethics.html
P: PO Box 123, BROADWAY NSW 2007
[Level 14, Building 1, Broadway Campus]
CB01.14.08.04

Ref: E13

Appendix 9: Ethics Site 1 University of Technology Sydney - Amendments

Subsequent approved amendments UTS HREC REF NO. 2015000415 & 2015000344.

UTS HREC Approval

R Research.Ethics@uts.edu.au Reply all |
Wed 3/06/2015, 11:55 AM
Janet Forber; Michelle.DiGiacomo@uts.edu.au; Research.Ethics@uts.ec

You forwarded this message on 22/06/2017 9:25 PM

Dear Applicant

UTS HREC REF NO. 2015000344

The UTS Human Research Ethics Expedited Review Committee reviewed your amendment application for your project titled, "Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches (Amendment to UTS HREC REF NO. 2014000652)", and agreed that the amendments meet the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that the Committee has approved your request to amend the protocol, which requested changes as follows:

1. Add the option of an alternative data collection method for staff participants, particularly Clinical Facilitators. In addition to existing options of attending a Nominal Group Technique workshop or semi structured interview to add an option to complete an online survey. The online survey would be based on the question plan that exists for the NGT workshop and semi structured interview, and comprise closed and open questions. This requires a new online questionnaire and revision of existing participant materials, the invitation to participate and Information Sheet;
2. Change to principal supervisor, from Prof Debra Jackson to Dr Michelle DiGiacomo and addition of supervision team member Prof Jane Phillips;
3. Changes to supervisor contact details on existing Participant Information and other documents from Prof Debra Jackson ¿ email Debra.Jackson@uts.edu.au to Dr Michelle DiGiacomo ¿ email Michelle.DiGiacomo@uts.edu.au; and
4. Revised completion date to 31/07/2015.

You should consider this your official letter of approval. If you require a hardcopy please contact the Research Ethics Officer (Research.Ethics@uts.edu.au).

To access this application, please follow the URLs below:
* if accessing within the UTS network: http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx
* if accessing outside of UTS network: https://remote.uts.edu.au , and click on "RMENet - ResearchMaster Enterprise" after logging in.

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
T: (02) 9514 9772
F: (02) 9514 1244
E: Research.Ethics@uts.edu.au
I: http://www.research.uts.edu.au/policies/restricted/ethics.html
P: PO Box 123, BROADWAY NSW 2007
[Level 14, Building 1, Broadway Campus]
CB01.14.08.04

Ref: E13

Fw: UTS HREC Approval

Jan Forber

Tue 23/01/2018 6:34 PM

To:Jan Forber <Jan.Forber@uts.edu.au>;

From: Research.Ethics@uts.edu.au <Research.Ethics@uts.edu.au>
Sent: Tuesday, 4 August 2015 4:23 PM
To: Janet Forber; Michelle.DiGiacomo@uts.edu.au; Research.Ethics@uts.edu.au; djackson@brookes.ac.uk
Subject: UTS HREC Approval

Dear Applicant

UTS HREC REF NO. 2015000415

The UTS Human Research Ethics Expedited Review Committee reviewed your amendment application for your project titled, "Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches (Second Amendment to UTS HREC REF NO. 2014000652)", and agreed that the amendments meet the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that the Committee has approved your request to amend the protocol as follows:

1. Student engagement: The following changes are aimed at supporting student participation in the research study:
a. Students have already received an initial email invitation and a repeat follow up email (initial email and sending several repeat emails were approved in the original HREC approval). Proposing to re-design an email reminder to participate into a more targeted final email(s).
b. Seeking approval during the final period of data collection (August 2015) to place reminder posters/flyers on student notice boards in Building 10 Level 6. Students will attend classes here in the Clinical Teaching Laboratories and these are areas used almost exclusively by the Faculty of Health;
2. To make available a paper copy of the on-line questionnaire, which students who volunteer, can complete at their convenience, such as between classes. It is proposed to offer students a one-off coffee shop voucher as a small reimbursement for their time and commitment to the study. Students can return completed questionnaires to a drop- box to maintain anonymity. If students have a smart device they may receive a coffee shop voucher with the existing Survey Monkey link to the online questionnaire attached to the voucher;
3. The original research proposal and HREC approval was for a 2 phase approach for student participation. Students were invited to complete an on-line questionnaire, with an option at the end, to volunteer to participate in a second phase and attend a NGT workshop. This amendment, seeks to revise the final email invitation and offer students to participate directly in a NGT workshop with light refreshments/ lunch provided, that is without completing the questionnaire phase first; and
4. Revised completion date: Data collection UTS 31-8-2015, Overall project completion 31/9/16.

You should consider this your official letter of approval. If you require a hardcopy please contact the Research Ethics Officer (Research.Ethics@uts.edu.au).

To access this application, please follow the URLs below:
* if accessing within the UTS network: http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx
* if accessing outside of UTS network: https://remote.uts.edu.au , and click on "RMENet - ResearchMaster Enterprise" after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm

If you wish to make any further changes to your research, please contact the Research Ethics Officer in the Research and Innovation Office, Ms Racheal Laugery on 02 9514 9772.

In the meantime I take this opportunity to wish you well with the remainder of your research.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
T: (02) 9514 9645
F: (02) 9514 1244
E: Research.Ethics@uts.edu.au
I: http://www.research.uts.edu.au/policies/restricted/ethics.html
P: PO Box 123, BROADWAY NSW 2007
[Level 14, Building 1, Broadway Campus]
CB01.14.08.04

E:13

Appendix 10 Ethics Site 2

Approval number STEMH 378

uclan
University of Central Lancashire

18 August 2015

Bernie Carter / Janet Forber
School of Nursing
University of Central Lancashire

Dear Bernie / Janet

Re: STEMH Ethics Committee Application
Unique reference Number: STEMH 378

The STEMH ethics committee has granted approval of your proposal application '**Undergraduate nurse clinical education: An appreciative dialogue to explore innovative approaches**'. Approval is granted up to the end of project date* or for 5 years from the date of this letter, whichever is the longer. It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Please also note that it is the responsibility of the applicant to ensure that the ethics committee that has already approved this application is either run under the auspices of the National Research Ethics Service or is a fully constituted ethics committee, including at least one member independent of the organisation or professional group.

Yours sincerely

Colin Thain
Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date