The development of a clinical reflective practice model for paediatric nursing specialist students in Indonesia using an action research approach

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

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 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.

Signature of Student

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Undertaking this PhD study was like riding a rollercoaster, sometimes I was up in the air, but other times I was at the bottom of the rail. At the end, a happy feeling fulfilled my heart when I was finally able to finish my PhD study, just like when the rollercoaster stop.

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Abstract

Reflective practice (RP) is extensively used to facilitate students' learning from their experiences and to improve practice. Despite substantial literature regarding RP effectiveness, Indonesian nursing education had not systematically applied RP within education programs. Most RP models have been developed and applied in Western countries with a number of studies indicating that culture may influence implementation in Eastern countries. This current study aimed to develop and implement a RP model that integrates Indonesian cultural characteristics to improve students' clinical learning. An action research (AR) approach was used with reflection as a core step in each cycle.

In AR cycle one, the researcher and six clinical educators developed a clinical reflective practice (CRP) model that considered Indonesian culture. The educators and 23 students implemented the model over a six months period. Data were collected through reflection sessions with educators and students conducted at the end of cycle one. Data were analysed separately for both groups with four themes from clinical educators (varied strategies used; towards self-development; avoiding behaviour; and areas for improvement) and five from students (making sense of RP; positive impacts; struggling with the writing process; uncertainty in supervision process; and supervision needs to be improved). These findings demonstrated that the CRP model was in the beginning stage of acceptance and needed some improvements.

In AR cycle two, the CRP model was revised in line with the findings from cycle one and was implemented over a three month period, followed by further data collection. Three themes emerged from the clinical educators' experiences (struggling with the implementation; challenging the culture; and students changing) and four from the students' experiences (developing expertise; feeling competent in practice; creating a safe space; and courage to speak up). An evaluation session held with students six weeks after completing their placement resulted in further themes (expanding their views, safe place, a light in the dark, self-awareness booster, and learning through experience). Findings indicate that clinical educators were still in a

process of accepting the CRP model, whilst the students gained more positive benefits, resulting in an enhanced learning experience.

The CRP model implementation highlights the cultural challenge for clinical educators in using a reflection process that resulted in students driving their own learning; thereby enhancing their overall learning experience. The resulting changes from the CRP model within the leading nursing education institution in Indonesia may influence other institutions to implement RP to improve students' clinical learning.

Abstrak (Bahasa Indonesia)

Praktik reflektif (PR) telah banyak digunakan untuk memfasilitasi mahasiswa belajar dari pengalamannya untuk memperbaiki praktik mereka. Meskipun telah banyak studi terkait efektifitas PR, pendidikan keperawatan di Indonesia masih belum menerapkan hal ini secara sistematis dalam program pendidikannya. Studi kepustakaan menunjukkan bahwa sebagian besar model PR dikembangkan di negara Barat dimana beberapa penelitian mengindikasikan bahwa budaya mungkin mempengaruhi implementasi PR di negara Timur. Penelitian ini bertujuan untuk mengembangkan dan mengimplementasikan model PR yang mengintegrasikan budaya Indonesia untuk memperbaiki pembelajaran klinik mahasiswa. Penelitian ini bertujuan untuk mengembangkan dan mengimplementasikan sebuah model PR yang mengintegrasikan karakteristik budaya Indonesia untuk memperbaiki pembelajaran klinik mahasiswa. Pendekatan Riset Aksi (RA) digunakan dalam penelitian ini dengan refleksi sebagai langkah utama dalam tiap siklusnya.

Pada siklus pertama RA, peneliti dan enam pembimbing klinik mengembangkan model Praktik Klinik Reflektif (PiKiR) dengan mempertimbangkan budaya Indonesia. Pembimbing klinik dan 23 mahasiswa mengimplementasikan model tersebut selama enam bulan. Data dikumpulkan melalui sesi refleksi dengan pembimbing klinik dan mahasiswa yang dilakukan pada akhir siklus pertama. Data dianalisis secara terpisah untuk dua kelompok partisipan dimana empat tema muncul dari pembimbing klinik (variasi dalam strategi; menuju ke pengembangan diri; perilaku menghindar; dan hal yang perlu diperbaiki) dan lima tema dari mahasiswa (berusaha memahami praktik reflektif; dampak positif; kesulitan dalam proses menulis; ketidakjelasan proses supervisi; dan supervisi perlu diperbaiki). Temuan ini menunjukkan bahwa model PiKiR ini berada dalam tahap awal penerimaan dan masih membutuhkan perbaikan.

Pada siklus RA yang kedua, model PiKiR direvisi sesuai dengan temuan pada siklus pertama RA dan diimplementasikan selama lebih dari tiga bulan, diikuti dengan pengumpulan data lebih lanjut. Tiga tema diidentifikasi dari pengalaman pembimbing klinik (kesulitan dalam implementasi; tantangan dari aspek budaya; dan

perubahan mahasiswa) dan empat tema dari pengalaman mahasiswa (keahliannya berkembang; merasa kompeten dalam praktik; rasa aman tercipta; dan berani berbicara). Sesi evaluasi dilakukan pada mahasiswa pada enam minggu setelah mereka menyelesaikan praktik klinik dan teridentifikasi beberapa tema lain (pandangan yang meluas; tempat yang aman; lampu di kegelapan; stimulasi kesadaran diri; dan belajar melalui pengalaman). Temuan ini mengindikasikan bahwa pembimbing klinik masih dalam proses menerima model PiKiR ini, namun mahasiswa mendapatkan manfaat yang positif dari model ini dalam hal peningkatan pengalaman belajar mereka.

Implementasi model PiKiR ini menekankan pada perubahan budaya pada pembimbing klinik dalam menggunakan proses refleksi yang berakibat pada mahasiswa mampu menentukan arah pembelajarannya sendiri; yang berdampak pada peningkatan pengalaman belajar mahasiswa secara umum. Perubahan yang terjadi dari model PiKiR ini pada institusi yang menjadi pusat pendidikan keperawatan di Indonesia dapat mempengaruhi insitusi lain untuk mengimplementasikan PR yang bertujuan untuk memperbaiki pembelajaran klinik mahasiswa.

1 Introduction and Background

Contemporary nursing education practice within the Indonesian university system is undergoing multiple changes to ensure that it meets international standards and provides the best possible health outcomes for patients. At times these standards are an uneasy fit with Indonesian cultural practices. Reflective practice is one such example that has been widely included into nursing curriculum in many countries; to date it has not been integrated into curriculum in Indonesia. This chapter consists of significant information that was the basis for conducting this research project. It begins with a description of Indonesian geographical and cultural characteristics, followed by a description of nursing education development in Indonesia. This information is presented in order to provide a brief but thorough picture of the research context. Furthermore, an overview of reflective practice and its implementation will be provided, as well as the cultural issues that might influence the use of reflective practice. At the end of this chapter, the significance of the study and a summary will be provided.

1.1 Indonesia: Its Geographical and Culture Description

Indonesia is a country that is located between two continents, Asia and Australia, and two oceans, the Indian and Pacific. It consists of approximately 17,000 islands and the total land area is approximately 1.9 million square meters. Most Indonesians live on the five big islands of Sumatra, Java, Kalimantan, Sulawesi and Borneo, and two groups of islands of Maluku and Nusa Tenggara.

Figure 1. A map of Indonesia

(Source: http://www.freeworldmaps.net/asia/indonesia/political.html)

According to the last population survey conducted by the Indonesian government in 2010, Indonesia has approximately 237.6 million people living in 33 provinces (Statistics Indonesia et al. 2013). The World Health Organization (2014) stated that Indonesia's population in 2012 was 247 million people; while data from the World Bank (2014) shows that the population is around 249 million people. Accordingly Indonesia is the fourth most populous country in the world and continues to grow in size.

Indonesia is known as an archipelago country that has hundreds of ethnic groups each with their own language. This makes Indonesia a very diverse culture. However, Indonesia has a national motto: "Unity in Diversity" which means that even though there are so many difference cultures, including languages, Indonesian people still unite as one nation. This national motto is the application of the third item in Pancasila, the Indonesian philosophy that is *Persatuan Indonesia* (Indonesian unity). For that reason, Indonesian society can be described as collectivist, which means that individuals in a group act based on the group's interest, because a group's interest is more important than an individual's interest (Hofstede, Hofstede &

Minkov 2010). In other words, if an individual's intention conflicts with the group's intention, then the individual should put forward the group's interest.

Besides being collectivist, another Indonesian characteristic is high power distance. High power distance refers to a significant gap in the society between individuals who have higher and lower positions in the community (Hofstede, Hofstede & Minkov 2010). For example, a teacher is positioned as having more power than the student in regard to their academic life; this places the student in a passive position (Burnard 2006). Furthermore, Hofstede, Hofstede and Minkov (2010) assert that students are more likely to not ask questions in the classroom since they want to keep a distance from the teacher (it is unusual that teacher and student have a close relationship). This is compounded by the students' avoidance of situations where they are afraid of being labelled 'silly' by asking questions that may be perceived as unimportant.

However, a major shift is occurring in education development within Indonesia over the past 15 years. The Indonesian Ministry of Education and Culture have started to apply a student-centred approach in all levels of education (Kusumawati 2010). This policy also applies within the nursing education system.

1.2 Nursing Education Development in Indonesia

Nursing education in many countries has undergone significant development. This phenomenon has also occurred in Indonesia. In the beginning, the entry for nursing education was at grade 10 and this was a hospital-based program. This program started in 1960 in order to fulfil the community health needs through nursing education development (Samba 2012). However, this program provided only foundation nursing knowledge and skills. The Indonesian government closed this nursing program in the 1990s.

In 1996, further nurse education programs were developed. The first Indonesian nursing education institution Diploma III level program was developed by the

Ministry of Health of the Republic of Indonesia. The focus of the Diploma III nursing program was to fulfil the needs of nurses working in a hospital or clinic settings (Samba 2012). From that time, many nursing education programs at diploma level were developed.

In 1983, the Consortium of Health Sciences agreed to develop a nursing program at tertiary level (Gartinah, Sitorus & Irawaty 2006). With assistance from WHO consultants in 1985, University of Indonesia created the first tertiary level nursing education institution. Today, there are over 280 tertiary institutions offering a Bachelor of Nursing degree program (Association of Indonesian Nurse Education Center 2015) and more than 425 institutions offering a Diploma III in Nursing program (Asosiasi Institusi Pendidikan Diploma III Keperawatan Indonesia 2015).

In Indonesia, the leader in nursing education development is the Faculty of Nursing University of Indonesia (FoN UI) in Jakarta. FoN UI is Indonesia's oldest professional nursing education institution. The vision of FoN UI is to be the leading center of nursing science and technology development and as a competitor for nursing development at a national and international level. Currently, FoN UI employes a large academic staff who have a dual role as lecturer and clinical educator.

FoN UI started the program for professional nurses in 1985 by offering a Bachelor of Nursing program. Then, in 1999, FoN UI launched a Master degree program with a major in nursing leadership and management. Currently, there are six majors in the FoN UI Master degree program. Five of these majors are nursing specialist programs in the area of community nursing, maternity nursing, medical surgical nursing, psychiatric nursing, and paediatric nursing. Nursing education development in Indonesia received its greatest impetus when FoN UI started a Doctoral program in 2008.

To become a nurse in Indonesia, the educational process commences in an undergraduate nursing degree program, which consists of two requirements, an academic program and a professional program. The undergraduate degree requires five years of study. Following completion, the registered nurse is able to continue

their study by entering a Master degree program; this is usually completed in two years (fulltime). To become a nurse specialist after graduation from a Master degree program a further one-year nursing specialist program is required. The final level of nursing education is the three-year (fulltime) Doctoral degree program. The nursing education pathway is illustrated in Figure 2.

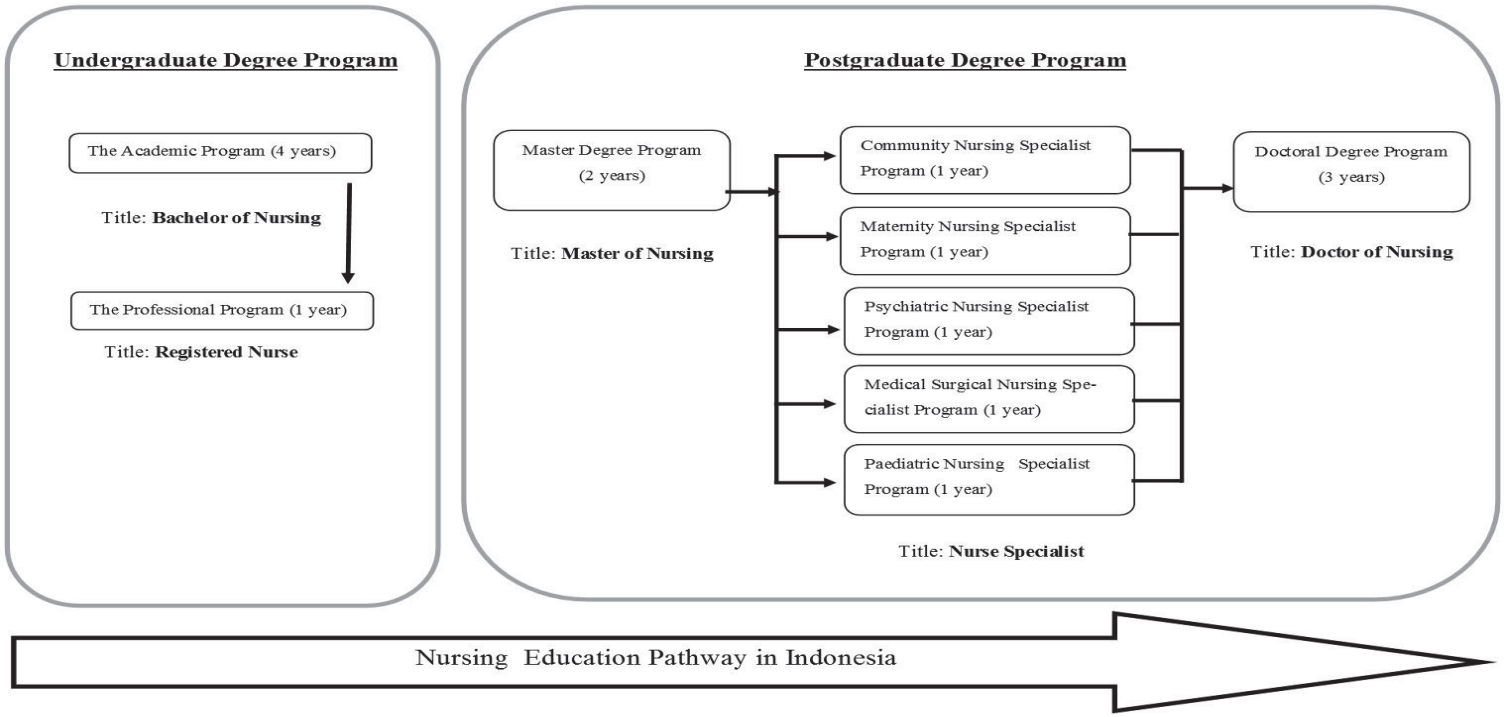

Figure 2. Nursing education pathway in Indonesia.

The FoN UI offers nursing education at a master level with several majors; one of the major offered is paediatric nursing. To graduate from this program, the students must complete 24 credits for the core unit (such as nursing science, leadership, ethics, quantitative and qualitative research, and management and information systems) and 16 credits in paediatric nursing subjects. All the subjects are provided in three semesters. In the fourth semester, the students are asked to conduct a research (thesis) as a partial fulfilment for the degree. The title for someone who graduates from this program is Master of Nursing.

Following the Master of Nursing, students will be enrolled in the Paediatric Nursing Specialist program. This program has a-one-year clinical practice period in the clinical settings. There are two semesters during the one-year program. In the first semester, the students participate in 14 weeks of clinical practice experiences in several paediatric wards. Then in the second semester, the student will practice in one chosen ward for 12 weeks. At the end of the second semester, the student will have two examinations, an oral and clinical examination. At successful completion of this study program, students who graduate from this program are entitled to be called paediatric nurse specialist. According to Figure 2, a qualified paediatric nurse specialist will have undergone a minimum of eight years of study.

This study was conducted in the Paediatric Nursing Specialist (PNS) program, where I have been working as a lecturer and clinical educator since 1998. There are nine academic staff who work as the lecturers and clinical educators in the program. Accordingly, the participants of this research project were my colleagues (fellow clinical educators) and students who were enrolled in the PNS program (in 2013/2014). Most students participating in this program are clinical educators from many of the Indonesian provinces. These students are qualified and experienced clinical educators in their own institutions. On completion of this program the students will return to their already established clinical educator roles, providing the potential to extrapolate the findings of their experiences in this study to a wider student nurse and registered nurse population. For instance, Geraldine who came from Sumatra enrolled in this program in 2013 already had 10 years of experience as a clinical educator in her institution. Geraldine is going back to her institution after

completion of the program where it is anticipated that she will share the findings of this study and the new knowledge and skills she has gained with her colleagues.

It is important to note that since 2012 I have been in Australia as a fulltime student. To conduct this study and collect data I returned back to the University of Indonesia for two periods: July 2013-to-January 2014 and February-to-June 2014. These periods of absence from the FoN UI allowed for some disconnect from my colleagues and the students. Further details about this are presented in Chapter Three.

1.3 An Overview of Reflective Practice as the Study Background

Reflective practice is a concept that has been used by nursing scholars for several decades. Some scholars identified reflective practice as a means of promoting the professional development of nurses (Johns & Watson 2000; Paget 2001). For other scholars concerns have been raised about the term and use of 'reflection', including a lack of consensual definition (Kinsella 2010; McBrien 2007; Teekman 2000), a lack of empirical evidence (Hannigan 2001; Hargreaves 2004), and concerns about expressing private thoughts to a wider audience (Cotton 2001; Ip et al. 2012).

In 1983, Schön developed the theory of reflective practice, based on Dewey's philosophy about how a person thinks about something (Dewey 1998). Schön's work on reflective practice was also influenced by "theories of action" which he developed with Argyris in 1974 (Schön 1987, p. 255). In that theory, Schön and Argyris proposed that there are reasons for someone's behaviour, indeed for a spontaneous action (Schön 1987). Later, Argyris (1976, p. 367) developed a model of learning which is called the "single-loop and double-loop model". Single-loop learning is when someone solves a problem without considering underlying values, whereas, in double-loop learning, the underlying values impacting on the situation are reviewed as part of solving the problem and determining the effectiveness of the action

(Argyris 1976; Greenwood 1998). Reflection occurs in double-loop learning, involving a process of looking back on the action taken to solve a problem and thinking through whether the action is effective or not. This type of learning is important in a field of study that contains professional knowledge, such as nursing. Schön (1983) stated that professionals often face uncertain situations in their practice, and reflection assists them to be more aware of their own practice – a crucial attribute for nurses which enhances patient safety.

There are two main sources of professional knowledge described as the high ground and the swampy low land (Schön 1987). The former high ground refers to the 'uncommon' problems that could be solved using formal inquiry. While the swampy low land focuses on common, but hard-to-define problems that are more difficult to solve. Schön's theory fits well with the nursing profession as both a science and an art. Nursing being identified as a science corresponds to the high ground in Schön's work, while the art of nursing is more abstract and therefore relates to the swampy low land (Johns 2009). For this reason, many nursing scholars use Schön's work as the basis or an introduction when they conduct research on reflective practice (for example see Asselin 2011; Forneris & Peden-McAlpine 2007; Horton-Deutsch, McNelis & Day 2012; Kim 1999).

A student who undertakes a nursing education program is encouraged to construct nursing as a science, as well as an art. Consequently, when participating in nursing care, a student nurse must consider the artistry of providing care to an individual patient (McCormack & McCance 2006). The way of interacting with one patient might be very different to another, depending on their age, health problems and environment support systems (McCormack & McCance 2006). In other words, a nurse must be an adaptive person (Fleischer et al. 2009; Tay, Hegney & Ang 2011). A student nurse is expected to learn these differences in order to develop their knowledge of nursing. Hence, the student is able to respond to the patients according to their different situations and needs.

According to Schön (1987), reflective practice is believed to facilitate a learning process, known as reflection-on-action and reflection-in-action. Reflection-on-action

is when the reflection process is undertaken on completion of an action, whilst reflection-in-action is reflection undertaken during the action (Schön 1983). During the learning process, for example, student nurses may apply reflection-on-action when they invest considerable thought into what occurred that day. For example, a student reflects on her decision to use drawing as a tool to explore anxiety in a hospitalised child. Conversely, reflection-in-action occurs when a student who is talking with a child realizes that the child is not interested, so they then change the communication technique with the child.

Building on these two aspects of reflection, reflection-for-action is introduced, this is when someone thinks carefully on what future action will be taken (Ghaye 2011). This type of reflection provides a guide before an action is taken based on a previous similar experience. These three types of reflection: reflection-on-action, reflection-in-action and reflection-for-action are now considered as the components of a cycle of reflection (Plack & Santasier 2003).

Reflective practice has been one of the most popular theories used by nursing scholars (Kinsella 2010; Thompson & Pascal 2012). It became a booming topic in early 90s. However, there remain many concerns about the lack of clarity around the concept of reflective practice (Duffy 2007; James & Clarke 1994; Kinsella 2010). In fact, several philosophers, such as Dewey (1998) and Boud, Keogh and Walker (1985) have raised concerns about the definition of reflective practice. According to Dewey (1998, p. 9), reflective thought is an "… active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends". In contrast, Boud, Keogh and Walker (1985, p. 43) define reflection as "… an important human activity in which people recapture their experiences, think about it, mull it over and evaluate it". These definitions highlight that learning from experience requires active critical thinking in order to find the knowledge embedded within the experience. However, these definitions demonstrate the difficulty of describing and quantitatively measuring reflection activities and outcomes, resulting in the potential for differing understandings of the meaning of reflective practice.

In spite of its unclear definition, many nursing researchers remain interested in exploring the benefits resulting from the application of reflective practice (Bulman, Lathlean & Gobbi 2012; Chong 2009; Coward 2011). From such research, it was found that reflective practice is beneficial when applied in both clinical practice and educational settings (Cox 2005; Hilliard 2006; Morris & Stew 2007). Reflective practice assists student nurses to develop skills in dealing with personal emotions that occur during clinical practice (Rees 2013), to better understand problems in the clinical setting and to increase their ability to solve the problems (Lie et al. 2010); as well as to develop critical thinking analysis (Forneris & Peden-McAlpine 2007). In nursing education, reflective practice provides a framework for designing graduate nursing curricula (Horton-Deutsch, McNelis & Day 2012) and supports registered nurses, who undertake further study, with a bridge to help them reduce the gap between theory and practice (Asselin 2011).

In Indonesia, a discussion about reflective practice emerged in 2006 when WHO consultants conducted a study to identify what Indonesian nurses needed to further develop their nursing practice (Hennessy et al. 2006a). In their study, Hennessy et al. (2006a) modified a survey instrument to be appropriate for an Indonesian context, which included items about reflective practice as one of the factors of the nurses' and midwives' roles. Hennessy et al.'s (2006b) study identified that respondents acknowledged items of reflective practice were important factors in clinical care and service management such as appraising their own and other's performance, and for recognizing and managing risk in clinical care. For that reason, they recommended regular case discussions as a means of continuing professional development (Hennessy et al. 2006b).

Since that time the notion of reflective practice has not been well defined within the curriculum and reflective practice approaches have been inconsistently applied during student nurses' clinical practice placement[1]. Anecdotal evidence suggests that

[1] This statement was based on the researcher's own experience.

only a few clinical educators[2] at FoN UI have started to integrate a reflective practice approach during the students' clinical practice placement. For example, a clinical educator might require students to complete an assignment focused on clinical learning by writing in a diary about the aims at the beginning of the day, and what they learnt during the day. The students submit their diary at the end of the clinical practice period in one ward before they move on to another ward. However, not all clinical educators have an opportunity to discuss what was in the diary with the student during the clinical practice period. A significant learning experience has been missed as there is no discussion about the diary content or ongoing reflection that focuses on the student nurse's experience, or indeed how the reflective activity is influencing their thinking and actions. As a result, the exercise may not have the rigour, or reflect the complexity of nursing practice that would be expected for reflective practice to be effective.

The above example provides an illustration of the ineffectual application of reflective practice attributes. According to Duffy (2007, p. 1402), the attributes that should be found in reflective practice application are examination of practice, reflexivity, an active and deliberate constructive process, and a process of transformation. There are limitations with the application of reflective practice in Indonesia as the existing process usually only fulfils one of the attributes, namely, an active and deliberate constructive process, since the students were actively involved in developing the report. However, the students may not even fulfil the first attribute as there is limited guidance during the activity. The process of transformation could not be determined as there was no discussion or feedback on what the students reported at the time of the experience or when handing in their reports. The inconsistent application of reflective practice in Indonesian educational settings is something that requires further investigation.

According to many nursing scholars, reflective practice is able to improve the student nurses' development during a clinical practice placement (Forneris & Peden-

[2] A clinical educator is an academic who supervise students in their clinical placement period. The similar terminology with clinical educator is clinical instructor, facilitator, or clinical teacher.

McAlpine 2007; Lie et al. 2010; Rees 2013). For example, reflective practice has been shown to facilitate paediatric critical care nurses' in changing their attitude toward family stress and enhancing their communication skills with the families (Peden-McAlpine et al. 2005). Through reflection, paediatric nurses question their routine practice, and as a result they may construct and conduct a new action based on the learning process they have experienced as an outcome of the reflection (Peden-McAlpine et al. 2005). Accordingly, it would be beneficial for both clinical educators and student nurses in the Paediatric Nursing Specialist Program to employ reflective practices, including reflection-in-action, reflection-on-action, and reflection-for-action, during the clinical practice placement.

Furthermore, the application of reflective practice during the learning process is particularly important because most of the students enrolled in the Paediatric Nursing Specialist Program are also clinical educators from different institutions in Indonesia. It is hoped that their postgraduate learning experience will increase their reflective practice knowledge and skills enabling them to incorporate reflective practice into their nursing practice and to become more effective clinical educators within their own institutions.

1.4 The Influence of Culture in Reflective Practice

A detailed exploration of the cultural influence in reflective practice, an important part of this study, was published as a paper in a journal: Wanda, D., Wilson, V. & Fowler, C. 2014, "East meets West in reflective practice", *Nurse Education Today*, vol. 34, no. 12, pp. 1417-9. The paper was developed as a collaboration between myself as the primary author (my contribution was in excess of 70%; for example conducting the literature review, leading the analysis, drafting the article and making changes after each revision) and my supervisors. A permission letter for use of the article in the thesis is provided in Appendix A. In the following section the published manuscript is provided.

East meets west in reflective practice

Summary

This paper addresses the importance of considering cultural characteristics prior to implementing reflective practice into nursing courses. Reflective practice implementation in Eastern countries raises challenges related to differences in the cultural characteristics between Eastern and Western countries. This paper will use Hofstede's framework to explore and identify the influence of culture on reflective practice in Western and Eastern nursing education and the implications this has for the future implementation of reflective practice in Eastern nursing education.

Key words: reflective practice, nursing, education, cultural, Eastern, Western

INTRODUCTION

Reflective practice

Reflective practice is a well-established concept in the education of professionals (Boud 2010). The ability to reflect in and on practice is recognised as a crucial professional skill (Schön 1987). Reflective practice is identified as assisting bridge the theory-practice gap by connecting what is taught about a theory and what is delivered in practice (Asselin 2011) enabling the linking and reinforcement of theoretical and practical knowledge (Hatlevik 2012). Reflective practitioners make this possible by utilizing a cyclical learning process; reflecting on past experiences in order to gain new knowledge about their practice and themselves as nurses (Johns & Watson 2000).

Learning from experience using reflective practice has benefits for nurses when applied in clinical practice and education settings. Reflection is used as a means of promoting the professional development of both student and practice nurses (Paget 2001). Reflection assists student nurses to: develop skills in dealing with personal emotions that occur during clinical practice (O'Sullivan et al. 2012), better understand and increase their ability to solve problems in the clinical setting (Lie et al. 2010), and develop critical thinking analysis skills (Asselin 2011). Reflective

practice also provides a framework for designing graduate nursing curricula (Horton-Deutsch, McNelis & Day 2012).

This paper uses four dimensions of Hofstede's (2011) framework to explore the influence of culture on reflective practice in Western and Eastern nursing education and the implications this has for the future implementation of reflective practice in eastern nursing education.

The Influence of Culture in Reflective Practice

Reflective practice has its origins and is predominantly used in Western countries (Minnis 1999) due to certain cultural characteristics often being present and contributing to reflective practice, for example, individualism and objectivity (Hofstede 2011). Nevertheless, the use of reflective practice in non-Western countries is growing in prominence amongst scholars (Stockhausen 2007).

A discussion is needed on whether it is important to consider a country's cultural characteristics prior to the implementation of reflective practice into nursing education and practice. Kawashima and Petreni (2004) claim that differences in Western and Eastern cultures may create conflict that impact nursing education, particularly an individual's way of thinking. Western knowledge which has been used in Japan is not sensitive to Japanese language, culture, and population characteristics (Stockhausen & Kawashima 2002). While Hancock (1999) identifies that students who come from countries unaccustomed to reflective practice may face a personal conflict due to the dissonance caused by these requirements and their country's culture dimensions.

Culture is defined as certain attributes shared by a society, which differentiate people who live in different places (Merriem-Webster Online Dictionary, 2014). The differentiation involves conventional beliefs related to racial, religious, or social group. For the purpose of this paper, culture will be defined as Western and Eastern cultures. Hofstede (2011) identified six dimensions of the culture differences between Western and Eastern countries. The first four have relevance for this paper: power distance; uncertainty avoidance; individualism/collectivism; and

masculinity/femininity. The final two dimensions will not be used due to their lack of significance to reflective practice: long/short-term orientation; and indulgence/restraint.

Culture Dimensions and Reflective Practice

Power distance

Power distance describes how society handles inequalities amongst its citizens. According to Hofstede (2011), power distance is the degree to which societies expect and accept unequal distribution of power. A large degree of power distance is experienced by people living in a hierarchical society (Minnis 1999) where everyone accepts they have a place within the society and this is not challenged. For example Thai society uses big person/little person to describe large power distance (Burnard & Naiyapatana 2004). Teachers are considered to have a higher-level position, therefore they are highly respected (Kim 1999) and are unlikely to challenge what is being taught. The teacher usually takes all the initiatives within the learning process. Consequently, the quality of learning depends on the teacher's ability and expertise (Burnard, 2005), and creates a dominant teacher-student relationship which may hinder the development of student's critical thinking abilities (Kawashima and Petreni, 2004). From the first author's experiences, such situations lead to phenomena where students are not highly motivated to think independently, they rely on the teacher to provide them with the knowledge.

In contrast, there is an expectation of minimal inequality amongst people who live in small power distance countries, resulting in them having interdependent relationships (Hofstede 2011). Students often treat their teacher as a friend and an equal. Students are expected to demonstrate initiative in the class, therefore the quality of learning depends on both the students and the teacher.

Power distance may influence the implementation of reflective practice, particularly in Eastern countries. In Chinese educational settings, the teacher is in a more power distance position than a student (Chiang, Chapman & Elder 2010). This hierarchy also occurs in Thai (Burnard 2006) and Japanese education systems (Stockhausen &

Serizawa 2008). Students' enthusiasm in improving themselves using reflection may be impeded in Eastern countries due to their belief that it is the teachers' responsibility to ensure student learning (Stockhausen 2007). If a student thinks the initiatives in the learning process is the teacher's responsibility, reflective practice has limited chance of being accepted as an appropriate practice.

Uncertainty avoidance

Uncertainty avoidance is the degree to which a society feels uncomfortable with insecure situations (Hofstede 2011). A society is considered as having weak uncertainty avoidance when they are being positively challenged in various situations and they become use to uncertainty. Societies with weak uncertainty avoidance in education settings will use open-ended learning situations, and encourage a robust student discussion between peers (Hofstede 2011).

Strong uncertainty avoidance societies have feelings of insecurity if they encounter ambiguous situations (Hofstede 2011). In the education setting, students prefer to have a structured learning program that includes knowing what to do and when to do it. Students are also concerned with obtaining the right answers from their teachers. They expect their teacher to provide correct answers in response to their questions. From the first author's experiences, students always ask for clear answers if they ask something in the classroom. Hancock (1999) states that some students give what they perceive is the required answer in order to avoid any unnecessary anxiety.

'Being different' creates uncomfortable feeling for people who have strong uncertainty avoidance (Hofstede, 2011). Strong uncertainty avoidance may result in a barrier occurring in the application of reflective practice. Thai nurses tend to have avoidance behaviour in uncertain clinical situations (Ekintumas 1999). If reflection is conducted without clear guidelines, it will lead to increasing negative feelings. In a study about reflective practice, (Joyce-McCoach et al. 2013) found providing clear expectation about students' reflective discussions assisted Chinese students in their ability to use reflective practice. This can be achieved by conducting an information session before reflective practice is introduced. The teacher is able to use strategies in reflective discussions so the students do not 'lose face' during the discussion.

Individualist versus collectivist

Individualism and collectivism refers to the power of a group in a specific society (Hofstede 2011). Individualist and collectivist dimensions can be differentiated based on how they positioned themselves in a group. Individualist is when people act independently or are not influenced by any societal group. People who are strongly influenced and depend on a group are called collectivist. The collectivist will put forward the group's interest rather than their individual interest since group loyalty is important.

Students from individualist societies are encouraged to speak on behalf of themselves, while in collectivist societies, students speak on behalf of the group or because they are authorised by the group (Hofstede 2011). In China, students are likely to avoid offering opinions in class because of two elements of Chinese culture: the belief that they may be 'losing face' and shyness (Chiang, Chapman & Elder 2010). The concept of 'losing face' can also be found in Thai culture, where students are encouraged not to challenge the teacher in order to avoid a situation where both the teacher and students may lose (Burnard & Naiyapatana 2004).

In regard to reflective practice, this characteristic may become an advantage as well as a disadvantage. If a student participates in reflection and is able to share the positive aspects of the reflection, other students may also be encouraged to participate in reflective practice. Moreover, Burnard & Naiyapatana (2004 claim a common Thai characteristic is to avoid expressing personal feelings.

Another characteristic distinguishing the individualist and collectivist relates to the purpose of education. Individualist societies focus on learning how to learn, whereas collectivist societies prefer learning how to do (Hofstede 2011), leading to different student and teacher behaviour. Teacher-centeredness is commonly found in the collectivist society because the teacher decides what should be taught. Chiang, Chapman and Elder (2010) identified that most of the teaching process in Taiwan is teacher-centered. In this study, some teachers were not prepared to adopt a new paradigm that focused on learner-centeredness.

Importantly, a teacher-centered approach has the potential to hinder a student's reflective abilities during the learning process; since the students are not used to thinking about their individual need (Chiang, Chapman & Elder 2010). They may not use their experiences in reflection due to the belief it will compromise their loyalty to the group. Asian students have been identified as preferring to maintain group harmony rather than to express their own ideas (Wurzel 1984).

Masculinity versus Femininity

The most common characteristics of people who live in countries where femininity is an accepted norms is being responsible for themselves, decisive, ambitious, caring and gentle (Hofstede 2011). In countries where masculinity is dominant, there are differences in women's and men's characteristics. A man is someone who is responsible for their family and the group, a man is to be decisive and ambitious; while a woman is required to be gentle and caring (Hofstede 2011).

The majority of nurses are women (Ekintumas 1999), and due to adherence to the masculinity concept, nurses in some countries are not ambitious and are supervised by medical doctors (often men) (Stockhausen 2007). Therefore, nurses and student nurses are not familiar with clinical practice being guided by reflective practice, as it requires taking responsibilities for their own knowledge and skills development. Burnard (2005) also identifies that the issue of 'losing face' due to doing something wrong, is commonly found in masculine dominant countries. Femininity and masculinity potentially influence the implementation of reflective practice in terms of the opportunity of students to offer opinions about patient care or nursing practice. Richardson (2004) supports this notion that female Arab students, living in male-dominated society are not permitting to think for themselves.

Points to Consider

When developing nursing practice approaches or nursing education programs in Eastern countries, four aspects require consideration regarding reflective practice: high power distance, collectivist, stronger uncertainty avoidance, and masculinity. High power distance may create people's unwillingness to confront issues openly

(Minnis 1999). Bakioǵlu and Dalgiç (2013) claim that in a homogenous culture, people tend to avoid conflict. Reflective practice is considered as creating inner-self conflict since reflection requires individuals to use past experiences to explore and challenge their attitudes, knowledge and skills (Johns & Watson 2000). To ensure the successfulness of reflective practice in Eastern countries, clinical teachers need to create a learning environment that encourages and supports a learner-centered approach to assist in decreasing the feeling and reality of a power imbalance between students and clinical teachers. As a result, students will increasingly be motivated to identify their own learning needs. Regular reflective discussion with students has the potential to increase the professional and collegial relationship with their teacher.

The concern of 'losing face' during reflective activities might hinder the ability to reflect on past experiences. Conducting individual reflective discussions rather than group discussions may assist students to minimize the risk of these feelings of 'losing face' and reinforce the student's efforts. Other strategies using indirect communication with students, such as written feedback, may also reduce risk and enable participation since the students do not have to be face-to-face with the teacher or be exposed to other students' comments (Burnard 2005).

The third dimension to be considered is strong uncertainty avoidance. To avoid this, educators are encouraged to provide students with clear guidance about reflection principles and value, and the reflective practice process (Glynn 2012). This guidance may also include providing reflective writing examples to assist students understand and develop their reflective skills and capacity.

The final issue relates to masculinity dominant norms in a country, where women are not encouraged to think critically or to focus on their experience and learning outcomes. Student must be encouraged and supported to accept that they must take responsibility for developing their professional knowledge and skills, and ensuring safe and competent nursing practice, regardless of their gender.

Concluding Thoughts

Successful implementation of reflective practice in nursing education and clinical practice requires consideration of the dominant cultural characteristics. Eastern characteristics that potentially impact on students' learning have been identified as high power distance, collectivist, stronger uncertainty avoidance, and masculinity. Such characteristics may become barriers to reflective practice implementation and future development as professionals. To deal with these cultural barriers, teacher may use strategies including providing clear guidance about the importance and use of reflective practice, conducting regular meetings, using indirect reflective activities, providing written feedback, and reflecting on and accepting differences between cultures. Such strategies may assist in dealing with the culture-related inhibitors to implementing reflective practice within nurse education programs. Finally, it is crucial teachers reflect on their nursing and teaching practice and have knowledge about their own and their students' cultural background (Santoro 2009). By accepting students' cultural characteristics, teachers increase their ability to facilitate learning through reflective practice.

REFERENCES

Asselin, M.E., 2011. Using reflection strategies to link course knowledge to clinical practice: the RN-to-BSN student experience. The Journal of Nursing Education 50, 125-133.

Bakioǵlu, A., Dalgiç, G., 2013. The Possible Barriers behind Reflective Thinking and Practice: Experiences of School Principals from Turkey and Denmark.

Boud, D., 2010. Relocating reflection in the context of practice.

Burnard, P., 2005. Issues in helping students from other cultures. Nurse education today 25, 176-180.

Burnard, P., 2006. Some attitudes towards teaching and learning in Thai nursing education. Nurse Education Today 26, 253-257.

Burnard, P., Naiyapatana, W., 2004. Culture and communication in Thai nursing: a report of an ethnographic study. International Journal of Nursing Studies 41, 755-765.

Chiang, C.-K., Chapman, H., Elder, R., 2010. Changing to learner-centred education: Challenges experienced by nurse educators in Taiwan. Nurse Education Today 30, 816-820.

Ekintumas, D., 1999. Nursing in Thailand: Western concepts vs Thai tradition. International Nursing Review 46, 55-57.

Glynn, D.M., 2012. Clinical judgment development using structured classroom reflective practice: a qualitative study. The Journal of nursing education 51, 134.

Hancock, P., 1999. Reflective practice--using a learning journal. Nursing Standard 13, 37-40.

Hatlevik, I.K.R., 2012. The theory-practice relationship: reflective skills and theoretical knowledge as key factors in bridging the gap between theory and practice in initial nursing education. Journal of Advanced Nursing 68, 868-877.

Hofstede, G., 2011. Dimensionalizing cultures: The Hofstede model in context. Online Readings in Psychology and Culture 2, 8.

Horton-Deutsch, S., McNelis, A.M., Day, P.O., 2011. Developing a Reflection-Centered Curriculum for Graduate Psychiatric Nursing Education. Archives of Psychiatric Nursing.

Johns, C., Watson, J., 2000. Becoming a reflective practitioner: A reflective and holistic approach to clinical nursing, practice development and clinical supervision. Blackwell Science Oxford.

Joyce-McCoach, J.T., Parrish, D.R., Andersen, P.R., Wall, N., 2012. Unlocking reflective practice for nurses: Innovations in working with master of nursing students in Hong Kong. Nurse education in practice.

Kawashima, A., Petrini, M.A., 2004. Study of critical thinking skills in nursing students and nurses in Japan. Nurse Education Today 24, 286-292.

Kim, M., Cha, C., 2012. Cultural meaning of course evaluation among nursing students and faculties in Korea. Nurse Education Today.

Lie, D., Shapiro, J., Cohn, F., Najm, W., 2010. Reflective practice enriches clerkship students' cross-cultural experiences. Journal of General Internal Medicine 25 Suppl 2, S119-125.

Minnis, J.R., 1999. Is reflective practice compatible with Malay-Islamic values? Some thoughts on teacher education in Brunei Darussalam. Australian Journal of Education 43, 172-185.

O'sullivan, A.J., Howe, A.C., Miles, S., Harris, P., Hughes, C.S., Jones, P., Scicluna, H., Leinster, S.J., 2012. Does a summative portfolio foster the development of

capabilities such as reflective practice and understanding ethics? An evaluation from two medical schools. Medical Teacher 34, e21-e28.

Paget, T., 2001. Reflective practice and clinical outcomes: practitioners' views on how reflective practice has influenced their clinical practice. Journal of Clinical Nursing 10, 204-214.

Richardson, P.M., 2004. Possible influences of Arabic-Islamic culture on the reflective practices proposed for an education degree at the Higher College of Technology in the United Arab Emirates. International Journal of Educational Development 24, 429-436.

Santoro, N., 2009. Teaching in culturally diverse contexts: what knowledge about 'self'and 'others' do teachers need? Journal of Education for Teaching 35, 33-45.

Schön, D.A., 1987. Educating the reflective practitioner: Toward a new design for teaching and learning in the professions. Jossey-Bass San Francisco, CA:.

Stockhausen, L., Kawashima, A., 2002. The introduction of reflective practice to Japanese nurses. Reflective Practice: International and Multidisciplinary Perspectives 3, 117-129.

Stockhausen, L.J., 2007. Developing culturally competent reflective practitioners. Part 1. Cultural reflections. Asian Journal of Nursing 10, 212-217.

Stockhausen, L.J., Serizawa, A., 2008. Developing culturally competent reflective practitioners. Part 2. The culturally responsive reflective practice model. Asian Journal of Nursing 11, 8-12.

1.5 Significance of the Study

This study aimed to develop and implement a model of clinical practice learning based on reflective practice. Despite being internationally practiced, reflective practice has not been adopted within Indonesian nursing education. The clinical reflective practice (CRP) model (for a description see Chapter Four page 88 and 97) The clinical reflective practice (CRP) model (for a description see Chapter Four) is a new clinical model and approach within Indonesian nursing education institutions. Currently, no Indonesian nursing education institution acknowledges the application of reflective practice as an approach to support student nurses' clinical practice; much less as a framework to develop the curriculum. This CRP model was developed by considering both the Indonesian culture and the context of nursing education in order to increase the feasibility and adaptability of the model to the Indonesian context. The initial CRP model was developed according to Gibb's reflective cycle and contextualised by considering both the Indonesian culture and the context of nursing education in order to increase the feasibility and adaptability of the model to the Indonesian context.

It is useful to implement reflective practice in education institutions to facilitate the professional development of student nurses, as well as the professional development of the clinical educators (Johns 2009; Paget 2001; Rolfe, Jasper & Freshwater 2010; Taylor 2010). Both student nurses and clinical educators need to actively work toward increasing their professional knowledge and skills. Students in this study were provided with opportunities to 'grow' professionally during their clinical placement. It is anticipated that this study will benefit the clinical educators (participants) and the researcher in enabling them to become reflective practitioners in their role as clinical educators. Moreover, according to Indonesian culture, a clinical educator is considered to occupy a higher position in academic society, and therefore they play a crucial role in facilitating clinical learning during supervision[3]

[3] In this study, supervision refers to activities conducted by clinical educators in the clinical settings which mainly consists of discussion about the students' progress, including patient care.

in the clinical practice setting. Reinforcing the clinical educators' reflective capacity is likely to improve the students' clinical learning process.

Another important aspect of this research project was the experience of participating in an action research study for the participants and the researcher. As far as the researcher is aware, some of her colleagues and all of the student nurses, who were participants of this study, have never conducted or previously been involved in an AR study. In other words, not only the researcher, but also the clinical educators and student nurses obtained valuable experience in undertaking an AR study by engaging in a research process that facilitated active involvement of the participants to improve their education and clinical practices.

1.6 Aim of the Study

This study aimed to:

1. Develop and revise a clinical reflective practice (CRP) model to fit the Indonesian nursing education context.
2. Implement the CRP model to clinical educators and student nurses during the students' clinical placement period.
3. Develop insight into clinical educators and student nurses experiences using the model through reflection.

1.7 Overview of the Thesis

This thesis is presented in nine chapters. The summary at the end of each chapter will be written in English and Bahasa Indonesia, in order to increase the access of Indonesian readers to this study and the dissemination of the findings.

Chapter One has provided a description of Indonesian demographic and cultural characteristics; as well as nursing education development in Indonesia as the context

of the study. An overview of reflective practice as the theoretical framing and background of the study has been presented followed by a manuscript about the influence of culture in reflective practice. The significance of the study is also provided in this chapter.

Chapter Two provides an analysis of the literature related to the development of reflective practice models that are applied within health professionals' education. From the analysis it was found that most of the reflective practice models were developed in Western countries. A reflective practice model consists of varied methods resulting in students being exposed to different learning experiences. A number of articles also describe the possibility of cultural influences on reflective practice model application. However, no further detail on how cultural influences impact on the ability to successfully use reflective practice within educational and clinical settings and what strategies can be used to avoid or minimize the influence of culture on reflective practice were provided.

Chapter Three presents the research design used in the study. The aim of the study was to develop and implement the CRP model into the student nurses' clinical placement period. The research method identified as the most appropriate approach was action research (AR). This chapter discusses how AR was employed in the study and the considerations that were necessary before conducting the AR cycles.

Chapter Four outlines activities completed in the first and second cycle of the AR. There were four phases in each cycle namely plan, action, observation and reflection. In this chapter, all phases are described along with the presentation of the CRP model and the revised CRP model.

Having established the action research activities in the first and second cycle, the findings from each AR cycle are presented in Chapter Five and Six. *Chapter Five* presents the findings of themes that emerged from reflection sessions (conducted separately for clinical educators and the student nurses) in the first cycle of AR. Subsequently, the findings from the second cycle are presented in *Chapter Six*. In addition, findings from an evaluation session held with the student nurses six weeks after the clinical placement period was completed are also presented in Chapter Six.

Chapter Seven presents the findings from an overarching analysis of the findings from the second AR cycle. In this chapter, interconnected themes between the clinical educators and student nurses will be demonstrated.

Chapter Eight provides a discussion of the key findings that emerged during the study period. This includes the richness of the students' learning; changes in the clinical educators' role and the engagement and active participation of the participants. The discussion focuses on how the culture influenced reflective practice and how reflective practice influenced the culture. The limitations of the study are outlined at the conclusion of this chapter.

Chapter Nine centres on my reflections captured during the study period and documented in my reflective diary. Four key areas found within the reflective diary that formed an important part of the action research process are discussed including the learning process of a novice action researcher; the experiences of an insider researcher; engagement with clinical educators and my relationship with the student nurses. Finally, the structured template of reflection developed in this study will be used to present the final thoughts on the research study.

2 Literature Review

2.1 Introduction

This literature review aims to determine the extent to which clinical reflective practice models have been studied and reported, in particular, the use of clinical practice models within an Indonesian paediatric nursing clinical placement setting. The search was conducted using CINAHL (EBSCO), MEDLINE (OVID), ProQuest Health and Medicine, Academic Search Complete (EBSCO) and SCOPUS (Elsevier) databases. In addition, the articles reference lists were reviewed to ensure that any relevant additional papers were identified and assessed.

The keywords used were *reflective practice*, *clinical education, student*, *nursing*, and *student nurses* (see Table 1). The search was limited to articles published between the years 2005-2015. The databases search yielded 1,072 articles of which none were about reflective practice in Indonesia.

Table 1. The searching strategies.

Source	Search terms / strategy	Results	Useful results
Academic Search Complete	(KW) Reflective practice AND (KW) Nursing AND (KW) Student	111	4
CINAHL	(KW) Reflective practice AND (MH) Education, Nursing, Practical OR (MH) Reflective Practice	601	5
MEDLINE	(KW) Reflective practice AND (KW) Nursing AND (KW) Student	49	4
ProQuest	(KW) Reflective practice AND (KW) Nursing AND (KW) Student	185	1
SCOPUS	(KW) Reflective practice AND (KW) Clinical education AND (KW) Student nurse	126	6

The inclusion criteria were: 1) research studies assessing the use of reflective practice; 2) used a model of reflective practice in health professional education; and 3) involved students. The exclusion criteria were descriptive studies on reflective practice, articles focusing on technical aspect of reflective practice, and articles published in language other than English or Indonesian. All duplicate articles were excluded. A total of 20 articles met the criteria and were used for this literature review (see Figure 3).

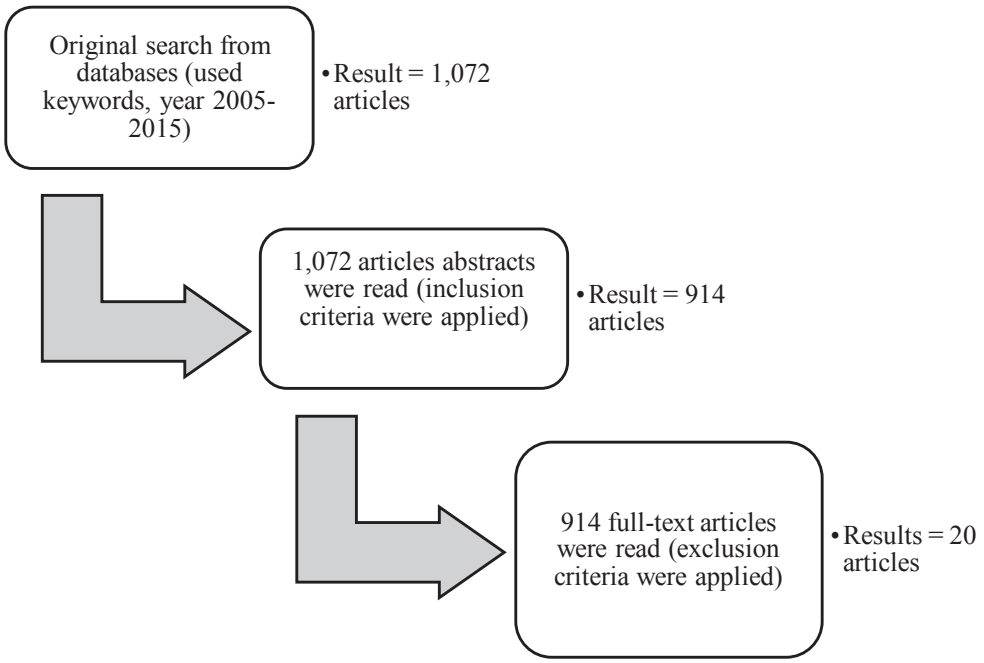

Figure 3. Search strategy result

Amongst the 20 studies, there were variations in terms of type of study, field of study, year of publication, research setting, and the research location. Most articles used a qualitative or mixed method approach, were conducted in developed countries and selected clinical placement as the setting for implementing a reflective practice model. A summary of the articles is provided in Table 2.

Table 2. Summary of reviewed articles.

Type of study	Qualitative	n = 11
	Mixed method	n = 6
	Quantitative	n = 3
Field of study	Nursing	n = 11
	Medical	n = 2
	Physiotherapy	n = 2
	Public health	n = 2
	Social work	n = 2
	Applied science	n = 1
Year of published	2005	n = 4
	2011	n = 3
	2013	n = 3
	2008	n = 2
	2009	n = 2
	2012	n = 2
	2006	n = 1
	2007	n = 1
	2014	n = 1
	2015	n = 1
Research setting	Clinical practice	n = 13
	Classroom	n = 5
	Online	n = 2
Location	United Kingdom	n = 6
	Australia	n = 3
	United States	n = 3
	China	n = 2
	Ireland	n = 2
	Germany	n = 1
	Malaysia	n = 1
	Sweden	n = 1
	Taiwan	n = 1

Participants involved in the studies also varied. Some studies involved only students (Chong 2009; Hughes & Heycox 2005; Ip et al. 2012; Laverty 2012; Manning et al. 2009; Morgan, Rawlinson & Weaver 2006; Roche & Coote 2008; Stockhausen

2005; Wen et al. 2015), other studies involved students and their clinical educators[4] (Clarke 2014; Cronin & Connolly 2007; Ekebergh 2011; Plack et al. 2008; Smith & Jack 2005). The number of student nurses involved in the projects varied from eight-to-116, whilst the number of clinical educator involved ranged from six-to-ten. Three themes were identified within the searched literature, namely a learning process through reflective practice, methods to facilitate reflection, and clinical educators' roles in reflective practice.

2.2 A Learning Process through Reflective Practice

From articles analysed in this review, the application of reflective practice in the classroom or clinical placement used either a structured or unstructured format. Fourteen out of twenty articles provides a structured model of reflective practice (Chong 2009; Cooke & Matarasso 2005; Cronin & Connolly 2007; Edelen & Bell 2011; Ekebergh 2011; Glynn 2012; Hughes & Heycox 2005; Ip et al. 2012; Laverty 2012; Lutz et al. 2013; Plack et al. 2008; Stockhausen 2005; Wen et al. 2015; Wilson 2011) and others used an unstructured model (Clarke 2014; Joyce-McCoach et al. 2013; Manning et al. 2009; Morgan, Rawlinson & Weaver 2006; Roche & Coote 2008; Smith & Jack 2005). A structured model referred to a structured format that starts with an introduction and is followed by regular sessions of reflection. Although all authors claimed that reflective practice models resulted in significant outcomes with regard to students' performance, studies that contained structured models were clearer at articulating the outcome.

In analysing the reflective practice models, three important questions arose: how was reflection applied in the learning process?; were there assessments within the

[4] In this study, a clinical educator refers to someone who works with students in the clinical practice setting. Some authors may use different names such as clinical teacher, clinical instructor, teacher, tutor, or facilitator.

reflective practice model?; and finally, what were the outcomes or changes in students' ability to reflect?

2.2.1 How was reflection applied in the learning process?

It is widely acknowledged that reflection is like a cycle, which mostly starts with an event or an incident. However, not many authors were explicit about using 'a reflection cycle' in their studies. Therefore, information about the reflection cycle was obtained from the description of the reflective practice model, regarding the order of reflective activities and its regularity. Several studies did provide detailed information about the reflection cycle used by the students (Chong 2009; Glynn 2012; Hughes & Heycox 2005; Ip et al. 2012; Plack et al. 2008; Stockhausen 2005; Wen et al. 2015). Gibb's cycle of reflection was the most structured model used to guide students in their reflection (Chong 2009; Ekebergh 2011; Wen et al. 2015), whereas one study used Rolfe's reflective framework (Edelen & Bell 2011) and another John's Structured Reflection Model (Ip et al. 2012). The reason for the more frequent use of Gibb's cycle was most likely due to the process for using the reflection cycle being structured and easy to follow. Gibb's cycle of reflection consists of six steps: description, feelings, evaluation, analysis, conclusion and action plan. These steps facilitate students to think in a structured format by answering questions provided in each step. This provides an explanation for why Gibb's cycle is commonly used within the learning process.

In regard to the type of reflection (Schön 1983), most studies focused on reflection-on-action, which required the students to reflect on their past experiences. In contrast, four studies described reflection-in-action activities (Edelen & Bell 2011; Laverty 2012; Plack et al. 2008; Roche & Coote 2008). It is recognised that reflection-in-action is a higher skill level for students to achieve. For example students involved in Roche and Coote's (2008) study were in their final year, therefore it is anticipated that they had higher clinical knowledge and skill levels to support them during the clinical placement; making it possible to ask them to reflect while participating in clinical work with patients. Similarly, Plack et al. (2008) conducted a study of reflection with doctoral and master students in a Physical

Therapy Program. In other words, Plack et al. involved physiotherapist students with higher level knowledge and skills to engage in reflection-in-action.

Some studies described in detail the students' learning processes during the implementation of a reflective practice model, particularly for the studies that used a structured model. Following an introduction session, several reflective activities, in the form of writing or discussion were held weekly (Edelen & Bell 2011; Glynn 2012; Laverty 2012; Plack et al. 2008) or less frequently but at regular intervals (Chong 2009; Cronin & Connolly 2007; Ekebergh 2011; Hughes & Heycox 2005; Wen et al. 2015). Towards the end of the reflective practice model implementation, a number of authors asked students to submit an individual reflective paper (Cronin & Connolly 2007; Edelen & Bell 2011; Hughes & Heycox 2005; Plack et al. 2008; Wilson 2011), have a reflective group discussion session (Glynn 2012), or discuss individual written reflective entries within a group (Ekebergh 2011; Wen et al. 2015). Because the authors used structured learning processes in implementing reflective practice, it can be inferred that learning occurred as a result of the application of the model. Those articles providing clear information about the model appeared to have a greater rigour as they also clearly outlined the research process in their articles (Chong 2009; Glynn 2012; Hughes & Heycox 2005; Ip et al. 2012; Plack et al. 2008; Stockhausen 2005; Wen et al. 2015).

An example of a structured reflective practice model was Plack et al.'s (2008), a group of physiotherapists, who conducted a research study on the implementation of a reflective practice model, both in the classroom and clinical placement settings. In their study, the students had a two-hour reflective practice introduction session, followed by weekly reflective entries that were submitted to an electronic board discussion. Peers were expected to comment on the reflective entries using reflective questions. At the end, the students were asked to submit a reflective essay about their achievements. Another study of structured reflective practice was carried out by Glynn (2012), where they aimed to examine the impact of structured reflective practice on nursing students' clinical judgment and confidence. The structured model consisted of a weekly traditional lecture followed by students' presentation on the patient care they provided. At the end of each presentation, the students were asked

to reflect on their patient care experiences. The students followed the structured reflective practice guide provided by the researcher.

Students' learning through reflection occurred individually (Hughes & Heycox 2005) or in a group (Cronin & Connolly 2007; Manning et al. 2009; Wen et al. 2015). For individual reflection, the authors aimed to facilitate the student's ability to focus on their personal experiences and feelings, and submit written reflections to their educator (Hughes & Heycox 2005). For other projects, the reflection entries were shared in a group, and the group members were encouraged to openly discuss the reflection (Cronin & Connolly 2007; Wen et al. 2015). The positive benefit for in-group reflection resulted in the students feeling that they had the opportunities to learn from other students' perspective, though some students did not like to listen to others' experiences (Cronin & Connolly 2007). Having smaller numbers of students in a group was believed to have created a better environment for reflective group discussion (Manning et al. 2009).

In regard to the research setting, most of the models were applied during the clinical placement period (Ip et al. 2012; Manning et al. 2009; Smith & Jack 2005; Stockhausen 2005), with the exception of a few studies where the models were applied in the classroom (Glynn 2012; Hughes & Heycox 2005). This conveys the idea that reflective practice can be applied in both classroom and clinical practice settings. Interestingly, two studies (Morgan, Rawlinson & Weaver 2006; Plack et al. 2008) also used an online forum to submit and discuss the reflective entries. For example Morgan, Rawlinson and Weaver (2006) used an online blackboard as a learning space where students could post their reflective accounts. Despite the longer time needed to complete the reflective activities in this study, students asserted that they reflected better than they had previously in the classroom (Morgan, Rawlinson & Weaver 2006).

In most reflective practice models, a learning process occurred when students discussed their thoughts and feelings about particular events (Hughes & Heycox 2005; Lutz et al. 2013; Morgan, Rawlinson & Weaver 2006; Plack et al. 2008; Wen et al. 2015). In other projects, students reflected on the critical incidents they

experienced during the clinical placement period (Edelen & Bell 2011; Plack et al. 2008). Cooke and Matarasso (2005) used a problem-based learning approach to stimulate students' critical reflection. They assert that the cases provided by the facilitator would assist in supporting students to explore the case in greater depth and breadth. This enabled the students to think from many perspectives, including physical, psychological, and cultural perspectives.

During the reflection session, feedback was provided for the students in some of the reflective practice models and came from the clinical educators (Roche & Coote 2008); peers (Hughes & Heycox 2005) or a combination of the clinical educators and peers (Cronin & Connolly 2007; Morgan, Rawlinson & Weaver 2006; Smith & Jack 2005; Wen et al. 2015). It was found that feedback from facilitators and other students assisted in enriching students' learning from their own experience (Wen et al. 2015). However, feedback from the facilitator and peers differed slightly; as the peer feedback focused on the issue being discussed and the action plan, while the facilitators broadened the discussion by providing other related alternatives for the issues being explored (Wen et al. 2015).

Another interesting result from an implementation of reflective practice was related to the influence of culture on students' reflection process (Chong 2009; Joyce-McCoach et al. 2013). Joyce-McCoach et al. (2013) found that Chinese students were hesitant to speak openly in the classroom because of two reasons; they felt obligated to understand what the teacher said and to avoid losing face, an embarrassment feeling, due to asking a simple question. Indeed, they preferred to line up after the class finished clarifying a statement or response, or asking the teacher a question. Similarly, a study of reflective practice in Taiwan, which also shares a similar Chinese culture, also found that the students avoided debates or confrontation in the classroom to avoid humility and conflict amongst them (Wen et al. 2015). While, the application of reflective practice in Malaysia did not present any cultural issues, which may be due to the author did not explore or relate the cultural issues to the study findings (Chong 2009).

In summary, a reflective practice model utilising a structured format or structured activities ensured a learning process that delivered clearer information and appears to provide more rigour to the process of reflection. The following discussion will be about the assessment of students' reflection ability.

2.2.2 Is there any assessment in the reflection ability?

It is generally accepted by academics that assessment is an important aspect for gauging the successful outcome of learning and education (Chambers 1998; Getliffe 1996). In some reflective practice models, an assessment is conducted in order to identify students' reflective ability. From the literature, several studies mentioned that students' reflections were assessed generally at the end of the study period (Hughes & Heycox 2005; Ip et al. 2012; Joyce-McCoach et al. 2013; Plack et al. 2008). Whilst, some authors utilised certain instruments (Ip et al. 2012), others failed to mention the criteria they used in the reflective skills assessment (Chong 2009; Cooke & Matarasso 2005; Plack et al. 2008). Two studies did not provide any information about assessment, even though the reflective practice model was integrated into a course conducted for the students (Cronin & Connolly 2007; Wen et al. 2015).

In clinical learning, it is beneficial for both the students and clinical educators to use the assessment as a part of the learning process as it provides an opportunity for giving feedback to students as well as the clinical educators (Gaberson, Oermann & Shellenbarger 2014). Nevertheless, not all authors mentioned that reflective skills should be assessed during the learning process. This may be due to a perception regarding the assessment of reflection outcomes that they are as of lesser value than the reflection process itself (Cronin & Connolly 2007).

In regard to identifying the changes in reflective ability during the study, Ip et al. (2012) used three levels of coding the reflective entries; these are non-reflector, reflector and critical reflector. The results of this study demonstrated that there was a significant increase (7.9 % to 63.2 %) in the number of students who were categorised as reflector after the reflective practice model was implemented.

Additionally, the students who were categorised as a critical reflector were also increased from 0 to 13.2%. This study highlights the potential for reflective entries to be assessed by comparing the entries from time-to-time when using a structured template.

Amongst the 20 studies, one study described the use of reflective practice as a tool to assess students' clinical performance in each semester (Chong 2009). This study was aimed at identifying how students perceived and interpreted reflective practice during their study period. The results of this study presented some negativity from the students' perception such as: the guideline provided was identified as being unclear; the students were not sure whether the reflective practice assessment matched with their competencies; and the students wrote the reflection as expected by the clinical educators, rather than how they really felt. This reveals an issue of lack of authenticity in reflection.

The issue of lack of authenticity also became a concern in Laverty's study (2012) when the students mentioned that there was a possibility to fabricate the reflective accounts when they knew the reflection would be assessed. Students were assessment-driven, which resulted in them focusing on activities related to the assessment that would influence their final mark. In other words, the students might be motivated to only fulfil the task without actively engaging with the reflection in order to create the best possible reflective entry in their journal. This situation also made the students hesitant to conduct a reflection with their clinical educator, resulting in the students preferring to do it with their peers (Roche & Coote 2008). Therefore, it is important that the clinical educator considers such impacts on the students before making a decision about the structure of the assessment process.

In brief, the literature suggests that assessment was not considered as important as the reflection process itself, since only eight out of 20 articles reported that they assessed students' reflective ability. Indeed, all reflective practice models analysed in this literature review claimed that the model had positive outcome in terms of the learning process and the development of students' reflective skills, no matter

whether they used assessment or not. The outcome of the reflective practice model will be discussed in the following section.

2.2.3 What is the outcome of using a reflective practice model?

The last aspect reviewed from the literature was the outcome of reflection or the changes in students' reflective skills following the implementation of a reflective practice model. In general, the outcomes of the application of a reflective practice model in the classroom or clinical placement were similar.

The authors who applied the model in the classroom highlighted that students gained benefits such as: becoming more open-minded (Hughes & Heycox 2005); they were able to prepare to become better health professionals (Wilson 2011); and they had improved clinical judgment in response to case studies (Glynn 2012). Students' negative comments on reflective practice were related to technical matters such as poor attendance at reflection sessions or not having adequate time to do reflections (Cronin & Connolly 2007). Interestingly, Glynn's (2012) study found that students' self-confidence rate decreased slightly. The author claimed that through reflection students realized that they needed to learn more. In other words, the students were developing insightfulness and becoming a lifelong learner. The author did not suggest any strategies to overcome the problem of reduced self-confidence.

During clinical placement, positive outcomes from the use of a reflective practice model outweighed any negative experiences. The positive outcomes of the model based on student nurses' perspectives, identified that using a reflective practice model facilitated students to explore emotional aspects during nursing care (Lutz et al. 2013; Stockhausen 2005); voice their thoughts (Wen et al. 2015); and it highlighted room for improvement in their practice (Laverty 2012). Reflection also assisted students to increase their level of reflection (Edelen & Bell 2011; Ip et al. 2012; Wen et al. 2015) and self-confidence (Roche & Coote 2008; Smith & Jack 2005). Students were able to manage complex and difficult situation which created a feeling of competence and satisfaction within themselves (Lutz et al. 2013).

Above all, reflection not only benefitted students as individuals, it also facilitated the improvement of clinical practice and health services (Laverty 2012; Lutz et al. 2013; Roche & Coote 2008). The improvement of health services occurred due to increasing clinical decision making ability (Edelen & Bell 2011) and the development of their self-awareness during the learning process (Chong 2009; Lutz et al. 2013; Manning et al. 2009). This awareness became an important outcome in the learning process, as increasing self-awareness is one of the aims for conducting and encouraging student reflection. From the clinical educators' point of view, it was found that the reflective practice model assisted them to have a better understanding of how students think and make decisions (Smith & Jack 2005).

Another mechanism for encouraging students' reflective process was through the use of Blackboard (online forum). Students' reported that they could do more extensive reflection in the online forum which might be due to being able to use their time more flexibly (Morgan, Rawlinson & Weaver 2006). An additional reason might be due to being in a private environment when conducting the reflection resulting in having time to think through their reflection and not having to directly interact with another person.

In four studies, students specified some negative feedback on the implementation of reflective practice (Chong 2009; Clarke 2014; Morgan, Rawlinson & Weaver 2006; Smith & Jack 2005) such as having to do more tasks related to reflection (Clarke 2014; Smith & Jack 2005). This occurrence might be a result of challenges occurring in integrating the reflective activities into the current curriculum. Consequently, they spent more time and effort on conducting reflections. This was experienced particularly by students in a study which used an online forum to post students' reflective entries (Morgan, Rawlinson & Weaver 2006). In this case, a possible reason might be due to technical matters related to the computer or the internet, even though this was not mentioned by the authors. While the students involved in Chong's (2009) study felt dissatisfied when they could not solve the problem they had encountered in their clinical practice through reflective activities.

In order to lessen the negative experiences for students, it is important to note the strength and weakness of several methods used to facilitate reflection in a reflective practice model.

2.3 Methods to Facilitate Reflection

In general, there are two strategies in facilitating students to reflect: written reflection and verbal reflection. Additionally, one study added observation as a reflection method. Of the 20 studies in the literature, two of them utilised writing only to facilitate students' reflection (Smith & Jack 2005; Wilson 2011), and five projects employed reflective discussion (Glynn 2012; Hughes & Heycox 2005; Ip et al. 2012; Lutz et al. 2013; Roche & Coote 2008). Other projects used both writing and discussion sessions in the model. The following sections will discuss issues found in both written reflection and reflective discussion.

2.3.1 Written reflection

To facilitate the development of reflective practice, most of the researchers utilized writing as a means to provide evidence of reflective practice, in the form of diaries, journals, or critical incident reports. Diaries or journals were useful to record students' progress (Smith & Jack 2005) and increase students' confidence for their next clinical placement (Roche & Coote 2008). Through written reflection, students were able to explore strategies for their future clinical experiences based on what they had learnt from previous experiences (Stockhausen 2005; Wen et al. 2015).

Issues that arose in regard to written reflections were the format used, the frequency of writing and the time constraints. In her study, Stockhausen (2005) employed unstructured writing during her research. This meant that students could write whatever they thought important on that day. Besides giving students an opportunity to write on their own, this type of writing might be challenging for beginning students who are not used to writing reflectively. In contrast, Cronin and Connolly

(2007) asked students in their study to use a structured template provided by the facilitator. This structure was aimed at assisting students to systematically reflect on their experiences. Half of the students mentioned that the template reminded them of the aspects they should consider in reflection (Cronin & Connolly 2007). It is easier to assess the changes in students' reflective journals if they used a similar structure each time they write the reflective entries (Chong 2009; Cronin & Connolly 2007). In regard to the decision on what type of writing, it depends on the objectives of the model and whether it will include assessment of the students' skills in reflection.

A second issue in written reflection, the frequency of writing, was also varied in the studies and ranged from daily (Stockhausen 2005), weekly (Edelen & Bell 2011; Laverty 2012; Plack et al. 2008), fortnightly (Chong 2009; Ekebergh 2011), to taking place once or twice during the clinical placement (Cooke & Matarasso 2005; Wen et al. 2015; Wilson 2011). Other studies only mentioned that the participants did regular writing entries without providing detailed information on how regularly the students recorded their reflections (Morgan, Rawlinson & Weaver 2006; Smith & Jack 2005). Interestingly, the students in Wilson's (2011) study reported that they were confused about the variations that occurred within written reflective assignment in regard to the frequency of the writing. It was suggested that regular writing could assist students to increase their familiarity with the reflective process, making it an easier and faster process (Smith & Jack 2005; Stockhausen 2005; Wen et al. 2015).

Another issue in written reflection is related to time constraint. Time limitation contributed to students' inability to effectively write reflective accounts (Laverty 2012; Smith & Jack 2005). In those studies, reflective practice was not blended into the clinical placement assignment and as a result students who participated in the study had to do reflections apart from (and on top of) their clinical assignments. This problem can be avoided by integrating reflective practice and its assignment into the clinical model during the research process.

Time constraint was not only a challenge to completing the written reflections, as students who used reflective discussion also complained about a lack of time being provided for them to reflect. Glynn (2012) stated that students who participated in

her study reported that they needed more time to reflect than was provided by the lecturer. Furthermore, several participants from Ip et al.'s (2012) study mentioned that the main reason for their withdrawal from the study was about the lack of time to write in the diaries. Further issues in verbal reflection will be discussed in the following section.

2.3.2 Verbal reflection

Besides writing narratives, there are other ways to facilitate reflection during clinical placement: presentation and discussion, both of which use verbal reflection. In the literature, discussion was effective as a means to provide feedback on the student's reflections (Wen et al. 2015) or share the reflective processes they had been through and exchange their thoughts and feelings about the experiences (Lutz et al. 2013; Stockhausen 2005). In Lutz et al.'s (2013) study, students reported that the discussion facilitated detailed understanding of a situation since it had been discussed by many students with different perspectives. Besides, discussion was also beneficial from the educators' point of view. Through discussion, a clinical educator was able to encourage and facilitate students to reflect on their experiences and assist the students to identify underlying theoretical knowledge that informed their actions (Cronin & Connolly 2007; Roche & Coote 2008).

In verbal reflection, three issues emerged related to the leader of the discussion, discussion duration, and the number of students involved in the discussion. From the literature, it was found that some discussions were facilitator-led (Cooke & Matarasso 2005; Cronin & Connolly 2007; Edelen & Bell 2011; Ekebergh 2011) or peer-led (Ip et al. 2012) whilst other researchers did not provide clear information about the discussion leader. A facilitator-led discussion might benefit students as there is an opportunity for the students to learn from their facilitator during the reflection process (Cooke & Matarasso 2005). To identify the influence of a facilitator or peer-led discussion, Plack et al. (2008) conducted a study which aimed to compare both types of discussion. They found that there was no significant difference in the students' reflective skills development. Nevertheless, it is important to consider students' readiness to lead a discussion during the application of a

reflective practice model. An experienced clinical educator will know the right time to involve students to lead a discussion with their peers.

The length of the discussion also differed amongst the studies in this review with. time spent reflecting ranging from one-to-two hours (Cronin & Connolly 2007; Lutz et al. 2013; Stockhausen 2005; Wen et al. 2015); or in some situations more than two hours (Hughes & Heycox 2005). This variation may have related to the objective of the reflective model used in the studies. The decision about the duration of the discussion sessions was perhaps dependent on the frequency of reflective sessions and the availability of a clinical educator who could facilitate the discussion. Stockhausen (2005) argued that a one-hour discussion was appropriate for the students since the discussion was conducted almost every day during the clinical placement period.

Other aspects for consideration in the application of a reflective discussion related to whether the discussion should be held in a small group which consisted of two-to-eight students (Edelen & Bell 2011; Ekebergh 2011; Lutz et al. 2013; Plack et al. 2008; Wen et al. 2015) or a larger group of more than eight students (Chong 2009; Cronin & Connolly 2007; Glynn 2012). The decision about the size of the group might be related to the fact that reflection in a group is about bringing private thoughts to a wider audience. Glynn (2012) suggested that most of the students were reluctant to participate in verbal reflections. This issue may have significant implications for when a reflective practice model is applied in cultures such as in Asian countries where discussing private thoughts in public may have cultural constraints and limitations (Minnis 1999).

2.3.3 **Observation**

Another interesting strategy to facilitate students' reflection was observation. Hughes and Heycox (2005) used observation in a course for students in social work. The students were asked to observe the interactions of older people with staff or other older people in a nursing home setting for one hour. Following the observation, the students were required to submit a reflective paper on their observation. The

reflective paper consisted of their reflection, related-literature or research discussion, and further practice implications. Most students in the study reported that the observation was challenging, but they obtained positive experiences from doing the observation (Hughes & Heycox 2005).

In summary, methods used in the reflective practice model were varied according to the objectives of the studies and whether it included assessment of the reflection.

2.4 Clinical Educators' Roles in Reflective Practice

Another important aspect to be discussed is the clinical educators' role within the reflective practice model. During the application of the reflective practice model within the clinical practice setting, students interacted closely with the clinical educators. However, the clinical educator role was defined differently amongst the researchers; in fact, some researchers did not even describe the role of a clinical educator in their research process. Two studies highlighted results related to the clinical educators' role (Chong 2009; Manning et al. 2009), 13 studies mentioned the clinical educators' role (Cronin & Connolly 2007; Edelen & Bell 2011; Ekebergh 2011; Glynn 2012; Ip et al. 2012; Lutz et al. 2013; Morgan, Rawlinson & Weaver 2006; Plack et al. 2008; Smith & Jack 2005; Stockhausen 2005; Wen et al. 2015; Wilson 2011), and five studies did not mention the clinical educators' role (Cooke & Matarasso 2005; Hughes & Heycox 2005; Joyce-McCoach et al. 2013; Laverty 2012; Roche & Coote 2008).

From the various studies analysed, a clinical educator had two main roles namely as a facilitator and a catalyst. A clinical educator who functioned as a facilitator had to ensure that reflective activities were applied during the clinical placement period (Cronin & Connolly 2007; Ip et al. 2012; Morgan, Rawlinson & Weaver 2006). In facilitating the students to participate in reflective practice, the facilitator sometimes needed to assist the students to identify an issue for reflection and to facilitate students to think critically (Chong 2009). A knowledgeable facilitator ensures the learning environment is non-threatening and comfortable to assist the students to

explore and reflect on their clinical experience (Lutz et al. 2013). Furthermore, if the facilitator provides appropriate feedback on the students' reflection, learning is more likely to occur (Edelen & Bell 2011). However, the facilitator's role in the reflective practice process is quite a challenging role due to lack of prior experience about the subject the students were reflecting on (Cronin & Connolly 2007). Lack of support from the clinical educators may have resulted in a negative reflective practice experiences for the student (Wilson 2011).

Being a catalyst was mentioned as the clinical educator's role in several of the studies (Ekebergh 2011; Smith & Jack 2005; Wen et al. 2015; Wilson 2011). To be a catalyst, the clinical educator was expected to provide responses to students' problems and issues discussed during the reflective activities in order to initiate discussion or the students' thinking process (Smith & Jack 2005; Wen et al. 2015). In this role, the clinical educator challenged the students to look at their experiences from different perspectives and this made the students obtain a deeper understanding of the situation (Wilson 2011). Ekebergh (2011) developed a model which used a reflective group supervision approach in order to facilitate students' learning about caring science theory. In regard to the learning process, the students had regular discussions with clinical educators from the faculty, who were knowledgeable in caring science theory and another clinical educator from the hospital, where the application of caring science was occurring (Ekebergh 2011). The students in this study felt that they were able to bridge the gap between theory and practice, in regard to the application of caring science due to the successful supervision process provided by the clinical educators.

To apply the role (facilitator or catalyst), there were two main points that need attention, namely the relationship between students and their clinical educator, and the preparation of clinical educators. From Ip et al.'s (2012) study, it was found that students sometimes faced difficulty in building a relationship with their clinical educator. One reason for this was identified as the clinical educators not always being available in the clinical setting to facilitate student discussions. This problem frequently occurred in those countries where there was an increase in student numbers with a limited number of educators (Morris & Stew 2007). A possible

outcome of this is if a student found it difficult to build a relationship, then the clinical educator may not be able to perform their roles appropriately. For that reason, it is important to ensure that clinical educators have adequate knowledge about reflective practice and skills and feel well supported in facilitating reflective practice within clinical placement settings that utilise a reflective practice model. Students in Chong's (2009) study expected that the facilitator in reflective practice had knowledge about reflective practice itself, so they could provide consistent feedback to the students. Furthermore, the clinical educators should consider and be sensitive to cultural beliefs and practices to ensure an appropriate approach is used to implement reflective practice (Joyce-McCoach et al. 2013).

In non-Western countries where hierarchical positions are considered important, a clinical educator has a higher position (status) than the student (Minnis 1999) and may be able to bring about changes in clinical education. Additionally, in such cultures, the teacher will be obeyed and followed by the students (Marambe, Vermunt & Boshuizen 2012). This respect for hierarchical positions clearly indicates that cultural aspects need attention in the application of a reflective practice model.

2.5 Summary

Findings from the literature indicated that very few research studies in nursing contained a reflective practice model, even though reflective practice is well-recognized within nursing education since the late twentieth century. From the literature, the concept of reflective practice has been applied in health professionals' practice, including educational and clinical practice settings. Nevertheless, the reflective practice models were varied in terms of the learning process, methods being used, and the outcomes of the model. Most of the studies were conducted in Western countries. It is noted that several scholars in non-Western countries, such as Asian countries, had integrated reflective practice into the nursing curriculum. However, no literature was found about the application of reflective practice in Indonesian nursing practice, either in educational or in clinical practice settings.

From the studies which were conducted in non-Western countries, there were similarities in term of they preferred to used structured model or regular interval of reflection in the model. This was an example of the application of stronger uncertainty avoidance as described in Chapter One. The information from these literature fit with one of the aim of the study: to develop a clinical reflective practice model that integrates Indonesian cultural characteristics.

Hasil dari studi kepustakaan menunjukkan bahwa sangat sedikit penelitian keperawatan yang berisi model praktik reflektif, meskipun praktik reflektif sudah dikenal sejak akhir abad ke-20. Dari kepustakaan tersebut, konsep praktik reflektif telah diaplikasikan pada praktik tim kesehatan profesional, termasuk di dalamnya pendidikan dan praktik klinik. Namun, model praktik reflektif yang ditemukan bervariasi dalam hal proses belajar, metode yang digunakan, dan luaran dari model tersebut. Sebagian besar penelitian tersebut dilakukan di Negara Barat. Perlu diketahui bahwa beberapa peneliti di negara selain Negara Barat, seperti Asia, telah mengintegrasikan praktik reflektif ke dalam kurikulum keperawatan. Namun, tidak ada kepustakaan yang ditemukan terkait aplikasi praktik reflektif pada praktik keperawatan di Indonesia, baik di lingkungan pendidikan atau praktik klinik.

Dari beberapa penelitian yang dilakukan di negara Timur, ditemukan persamaan dalam hal bahwa mereka lebih memilih untuk menggunakan model yang terstruktur atau refleksi dilakukan secara reguler. Hal ini merupakan contoh dari aplikasi strong uncertainty avoidance seperti yang telah dijelaskan di Bab Satu. Informasi yang didapat dari studi kepustakaan ini sesuai dengan salah satu tema dari penelitian ini yaitu mengembangkan model praktik klinik reflektif yang mengintegrasikan karakteristik budaya Indonesia.

3 Research Design and Methodology

3.1 Introduction

The literature review in the previous chapter highlights benefits students may obtain from reflective practice. However, very limited studies using reflective practice models have been undertaken in Asian countries, including Indonesia. Therefore, this study developed and implemented a clinical reflective practice model which integrates Indonesian cultural characteristics (high power distance, collectivist and stronger uncertainty avoidance) for use by student nurses and their clinical educators.

The methodology for a research study depends on a variety of factors including the study aims and anticipated outcomes, the intent of the study, the context in which the study is taking place and the experience of the researcher. It is important to define and decide which research approach is chosen at the beginning stage of a research process. Therefore this chapter begins by outlining the research approach and theoretical underpinnings of the study.

The study design and methodology will then be described, including the setting, recruitment process, participants, data collection procedures, data management and storage, data analysis procedures, and rigour. Issues related to the translation process in the CRP study, as well as ethical issues are also presented in this chapter.

3.2 Action Research as an Approach

3.2.1 Brief history of AR

This section will present a brief history of AR in responding to social problems, including the development of AR in the disciplines of Education and Nursing. Kurt

Lewin was a social psychologist who began to use the term 'action research' in the1940s. Lewin (1946) believed that the most appropriate type of research in social practice is action research. In his work, Lewin found that people were more likely to be motivated to do their work if they take ownership of the work; as a democratic approach was more effective than autocratic coercion as a way of increasing the productivity and morale of employees (Adelman 1993). This participative notion became one of the main feature in AR, and for this reason the position of the participants in AR who are expected to actively contribute may be different to the participants in other research approaches where they take a more passive role.

In the early years of its development, AR focused on social action and change, while AR today also aims at encouraging practitioner problem solving (Bensimon et al. 2004), facilitating learning (Grundy 1982) and generating or testing theory (Titchen & Binnie 1993). In his AR study, Lewin (1946) aimed to assist employees to identify their current practice situation, the existing obstacles, and alternatives to deal with the situation related to intergroup relations among the majority and minority. Lewin developed his theory based on Habermas's Critical Social Science (Carr & Kemmis 2003) which argues that knowledge comes from human action and is driven by needs and interests. This notion challenges the idea of many traditional research approaches that claim knowledge is out there to be found, and the process of knowledge generation should be controlled and objective.

Furthermore, AR was developed due to the dissatisfaction of research scholars who identified that research results were often not practical or usable, and seemed not to be applicable in the real world (Badger 2000). Schön (1987) claimed that most of the problems in the real world are in the swampy low land (for example in clinical practice) and not many research scholars produce research results from that swampy low land. The participative feature of AR requires participants to actively contribute to the research process, making problems that lie in the swampy low lands more likely to be resolved. This active contribution involves identifying the problem, planning and implementing the action, and reflecting on the process. Whilst there is no consensus on the definition of AR it is generally defined as an inquiry process

involving collaborative or participatory action in order to solve a problem or to improve practice in a particular context.

In the 1950s, AR became a well-known approach in the discipline of education, as a form of practical research that legitimised teachers' attempts to understand their work from their perspectives (McNiff & Whitehead 2011). Stephen Corey is renowned as the first scholar who developed AR within the discipline of Education. Corey (1949) believed that practitioners at school are responsible for identifying new findings to improve their own practice. For this reason, he argues that an insider researcher's (teachers as the researcher) position would improve the process of acceptance of the research findings and implementing the findings into practice. Action Research in education should be an active and intentional work, that may have consequences for the teacher's practice (Sanders & McCutcheon 1984).

Today, AR is widely used in many disciplines, including nursing, as a form of professional learning, as AR assists practitioners to investigate their own practices and make improvements (Greenwood 1994). Traditional research approaches do not aim to support continuous and responsive practice improvement by the practitioners (Rolfe 1996). According to Titchen and Binnie (1993), an AR approach uses a bottom-up strategy enabling nurses not only to improve but also develop personally and professionally. Nurses are the first amongst health professionals who have used AR (Titchen 2015) to improve the quality of care by effectively bridging the gap between nursing theory and practice (Hart 1996).

In nursing, AR studies have been conducted with the focus on both nursing education and nursing practice. For example in nursing education, an AR study was conducted to improve students' experiential learning using actors in simulation (de Oliveira et al. 2015); whilst a participatory AR project aimed at investigating changes occurring in an interdisciplinary team in pain assessment (Larsson & Blomqvist 2015) is an example of AR in nursing practice. Both studies aimed to improve nursing practice. However, Larsson and Blomqvist's study clearly demonstrated rigour within their study increasing the possibility of transferability of

an improvement (in assessing pain) as an outcome of changed nursing practice to other clinical settings.

3.2.2 Justification of AR as the research approach

AR was identified as the appropriate methodology for the CRP study based on three reasons: it enables the facilitation of a reflective process; it facilitates an improvement within an individual's practice; and it increases equality in the social context. First, reflection is the inherent component of AR and requires the researcher to embed reflective practice activities within the AR study (Elliott 1991; Reason & Bradbury 2006). This study developed and implemented reflective practice that integrated Indonesian cultural considerations. In the CRP model, the clinical educators and students used reflection in their practice. Clearly, AR and reflective practice have been simultaneously embedded within the AR cycle (McIntosh 2010). In undertaking this AR study on reflective practice, the researcher and participants used reflective skills to conduct the research as well as to achieve the research objectives.

The second rationale was its appropriateness as a method to achieve the study objective of developing a reflective practice model to be implemented in the particular setting where the researcher works. Costello (2011) acknowledged that AR is an excellent approach when practitioners are concerned with investigating their own practices. This study took place in one department, in one institution, in order to deal with a particular problem in a small population (Kemmis & McTaggart 1988). Crucially, the intent of this study was about engaging the clinical educators, as the participants, for whom the change in practice has a direct impact. This participation of the clinical educators created a potential for increased commitment to the practice innovation and participant capacity building; increasing the likelihood of sustaining the practice innovation.

The third rationale was because AR is believed to be able to increase equality in the social context (Reason & Bradbury 2006). For this reason, AR is the most appropriate approach in conducting research in a country where inequality is

common, like in Indonesia. In AR, all participants (in this study referred to the clinical educators and student nurses) have an equal role and therefore this approach was expected to be able to reduce the high power distance between Indonesian clinical educators and student nurses by actively engaging both of them in the research process.

3.2.3 Forms of AR

According to Carr and Kemmis (2003), there are initially three forms of AR approaches: technical, practical, and emancipatory. Additionally, another form of AR approach which is called transformational AR was introduced by McCormack and Titchen (2006). In general, all four forms of AR are similar in regard to their general aims that focus on changes to improve practice. These forms of AR have slight distinctions between one another as presented in Table 3.

Table 3. Differences of AR forms

Forms of AR	Technical AR	Practical AR	Emancipatory AR	Transformational AR
What this AR focuses on?	Concern with effectiveness and efficiency of practice	Concern with collaboration between an outsider researcher and the participants	Concern with enabling process of practitioners in their own practice	Concern with enabling process of practitioners in their own practice by adding creativity and human flourishing
What is the aim of the AR?	To improve practice through participants' practical skills	To improve practice by developing practical reasoning or personal wisdom in the practitioners	To improve own practice using reflective practice	To improve own practice through creative approach and human flourishing to achieve the maximum individual's capability
Who conducts the AR?	Is conducted by a researcher who is regarded as an expert in the field	Is conducted by a researcher to work alongside the participants	Practitioners take joint responsibility to conduct any effort to improve their own situation	Practitioners who use creative methods as well as the common method in research
Who owns the AR?	Participants are the subject of the research	The researcher works with the participants	Participants are the co-researcher	The researcher and participants are interdependent
Study examples	A study aimed that developed and implemented a daily living plan for hospitalized elderly individuals before discharge (Reed 2005)	The researchers worked collaboratively with lecturers and senior lecturers in order to develop models of writing essays for students in their final year. (Friberg & Lyckhage 2013)	The changing practice of the researcher and her colleagues as occupational therapists are described (Duggan 2005)	The improvement of practices in residential units for the care of older people using person-centred approaches that employed critical reflective inquiry through personal narratives (Cardiff 2012)
The CRP study	-	I worked alongside the clinical educators and student nurses, in facilitating them using the CRP model.	The CRP study focus was to improve the clinical educators' (all were my colleagues since I also acted as a clinical educator prior to the CRP study) and student nurses' practice during clinical placement period.	-

(Carr & Kemmis 2003; Grundy 1982; Titchen 2015)

A *technical AR* approach has been critiqued for the lack of participation due to the idea for the research generally coming from the researcher who then plans the action to be implemented by the participants. For that reason, there is a possibility that the changes occurred during this technical AR would not be sustained for very long after completion of the research (Titchen 2015). Unlike technical AR, participants generate the research problem in a *practical AR* (Grundy 1982); which also locates power with the participants. The researcher's role in practical AR is more aligned to that of a consultant assisting the practitioners to improve their practice. A challenge is present for the researcher who is acting as a consultant, they must be able to maintain participation of the AR participants during the AR process.

In *emancipatory AR*, the focus of the AR is the emancipation of the participants to improve their own practice through engaging in critical reflections. Critical reflection is the important aspect in AR study described by Grundy (1982) which leads to knowledge generation during the emancipatory AR process. Meanwhile, in *transformational AR,* the distinct features are the integration of a creative approach and human flourishing to assist individuals achieve their maximum capability (Titchen 2015). In this type of AR, knowledge is produced through the creativity and human flourishing to improve the practice.

In this CRP project the AR form was not clear-cut as it included elements of both *emancipatory* AR and *practical* AR. The focus and aim of the CRP study matched the characteristics of emancipatory AR (refer to Table 3): as the focus was on the enabling processes of the clinical educators and student nurses and it aimed to improve clinical educators' and students' practices during the clinical placement. It also has characteristics of practical AR (as can be seen in Table 3) as I worked alongside the clinical educators and students. In other words, the CRP study was not clearly an emancipatory or practical AR study, as it traversed the boundaries between the two approaches. Nevertheless, an important issue which needed to be considered was the researcher position (as described in Table 3); as prior to the CRP study I was one of the lecturers for the student nurses and a colleague of the clinical educators. This position might impede the element of emancipation in the CRP study. A discussion about the researcher position can be found in the next section.

3.2.4 **Researcher position**

A researcher's position in an AR study is different compared to researchers in more traditional forms of research. In a traditional research approach, the researcher generally keep a distance from the research subjects in order to avoid bias, however in AR the researcher actively engages with the participants and is involved in problem solving (Greenwood & Levin 2007). Lewin (1946) as the initiator of AR argues that practitioners should be involved in the change process where the social problems are occurring. The role of the participants is as important as the role of the researcher in AR, starting with identifying the problem, planning and participating in the action, and evaluating the effect of the change. In the CRP study, the involvement of the clinical educators started in the early stages of the research study design. Their participation was important due to their ability not only to consider the integration of Indonesian cultural characteristics, but also to determine the feasibility of this AR study. This decision was supported by Reason and Bradbury (2006) who claim that AR requires participants to actively participate in order to identify practical solutions to solve the problems that arise.

An action researcher may also have multiple roles during the AR study such as a researcher, change agent and facilitator. McNiff and Whitehead (2011) assert that AR should be conducted by insider researchers because AR is aimed at improving one's own practice, while a different view comes from Kemmis (1996) who claimed that AR is an expression of social research, therefore it is not necessarily conducted by insider researchers. My role was an insider researcher, which according to Leung et al. (2010) had several benefits: easier access to the source of data; better understanding about the context that possibly enables easier initial engagement and interpretation; and potentially an increased significant impact on the participants.

The position as an insider may potentially created negative consequences such as the data being 'thinner' as participants at times may be reluctant to share and explore sensitive issues and prior experiences (Mercer 2007). This reluctance to share sensitive issues was demonstrated by the students in the beginning of this study. This issue was solved when I emphasized the confidentiality of the research process

several times and trust began to develop between the participants and me as the researcher. The use of various questioning technique during the discussion and individual interviews with the students facilitated the students' confidence and ability to express their feelings or opinions regarding the CRP study. Meanwhile, this issue did not occur for the clinical educators who readily shared sensitive issues such as how they could not manage their time or their struggle in acknowledging a more equal position with the students following the implementation of the CRP model. The awareness of benefits and negative consequences of being an insider researcher (as described in more details in Chapter Nine) assisted me in maintaining the critical element of the CRP study.

3.3 Study Design

Kemmis and McTaggart (1988) prominent AR educational scholars use principles of AR that match those of the CRP study, therefore their definition of AR (Kemmis & McTaggart 1988, p. 5) was used to guide the CRP study.

> A form of collective self-inquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out.

From this definition, AR is an approach to improve one's own practice in an educational setting, which is based on collective self-inquiry. This approach was consistent with the aim of this study, which was to develop and implement the CRP model to improve student nurses' clinical learning.

Kemmis and McTaggart's (1988) model of AR consists of four phases: plan, act, observe, and reflect. The first phase in the cycle (plan) enables the researcher to identify a problem that could be improved by an action. Kemmis and McTaggart (1988) suggest that to start a plan one does not necessarily need a problem, because even a general idea about something that could be improved is a starting point for an

AR study. In the second phase (act), the researcher needs to enact the plan thoughtfully and constructively. The action phase is a dynamic process, where the researcher plays an important part. Following that, an observation (phase 3) of the action process and its effects takes place. The observation must be planned and should document all the expected and unexpected events during the action. Afterwards, the researcher can use such documentation to conduct critical reflection about the research process, the final phase of the AR process. Reflection can be undertaken through discussion with participants during the research process. All these phase are described by Kemmis and McTaggart as "moments of action research" (1988, p. 9) as can be seen in Figure 4.

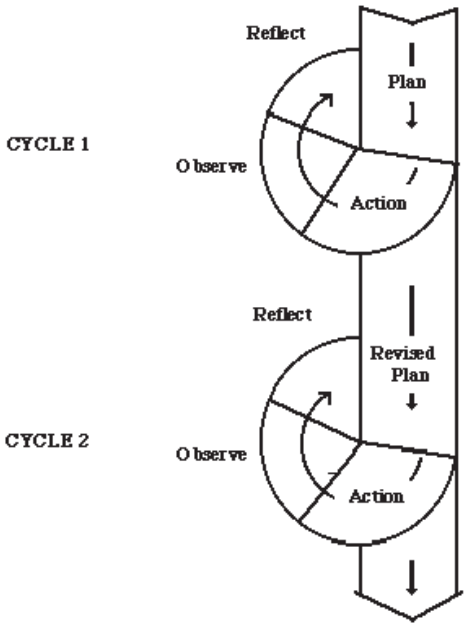

Figure 4. Kemmis and McTaggart's moments of action research

In regard to the CRP study, Kemmis and McTaggart's cycle of AR was adapted during almost one year of data collection: the first AR cycle was in July-December 2013 and the second AR cycle was in February-June 2014. The summary of activities in each step of both cycles can be seen in Table 4. Details information about activities in the first and second AR cycle can be found in Chapter Four.

Table 4. Summary of the activities in the CRP study.

First AR cycle				
Time allocated	Plan	Action	Observation	Reflection
	July-August 2013	September-December 2013	September-December 2013	December 2013
Activities	• Engaged with clinical educators to develop the CRP model	• Conducted a workshop to prepare clinical educators prior to the implementation of the CRP model • Engaged with clinical educators during the CRP model implementation • Engaged with students and conducted a workshop to prepare them prior to the implementation of the CRP model	• Observed clinical educators on how they facilitated students in the CRP model • Observed students on how they used reflection during the clinical placement period	• Conducted separate critical discussion with the clinical educators and students • Conducted individual interviews with the clinical educators and student nurses
Second AR cycle				
Time allocated	Re-Plan	Action	Observation	Reflection
	February 2014	February-April 2014	February-April 2014	May-June 2014
Activities	• Revised the model with several clinical educators • Presented the revised model to the students	• Clinical educators and student nurses implemented the CRP model • Engaged with the clinical educators and students during the implementation period	• Observed clinical educators and students on how they implemented the revised CRP model	• Conducted individual interviews with clinical educators • Conducted critical discussion with students • Conducted an evaluation session with the students.

3.3.1 The Setting

The Faculty of Nursing University of Indonesia (FoN UI), the oldest nursing education institution in Indonesia, was the study site. Eleven academic staff are assigned as member of Paediatric Nursing Department; nine of them, including myself prior to this study, were responsible for conducting the learning process in the Master degree and Paediatric Nursing Specialist Program.

The students enrolled in the Paediatric Nursing Specialist Program between 2009-2014 ranged from 8-34 students per year. At the time of data collection, the number of students enrolled were 23 students. Students who were enrolled in this program came from different provinces in Indonesia. All of them are already clinical educators in their institutions.

3.3.2 Recruitment Process

There were two cohorts recruited for this CRP study in two stages. The first stage recruited the clinical educators who supervise student nurses during their clinical placement. In the second stage the postgraduate student nurses enrolled in the Paediatric Nursing Specialist Program who will be using the CRP model were recruited.

As Lewin (1946) emphasizes that practitioners should be involved in the change process, the recruitment process became a key point in starting the CRP study. The involvement of the clinical educators in developing the CRP model assisted in identifying the practical solutions for improvement in students' clinical learning (Reason & Bradbury 2006) resulting in an easier process of acceptance of the CRP model. Details about the recruitment process can be found in Chapter Four.

In the second stage of the participant recruitment, the introductory session was repeated for 23 student nurses. To minimize the high power distance between the students and I, as their previous teacher, clarification was provided about my current role as the researcher and as a PhD student. In that session, I emphasized that I

would be involved in their learning process. However, I would not be involved in any assessment during the learning process. In regard to that, the relationship that I would have with the students was a researcher-participant relationship, not a lecturer-student relationship. Additionally, the students were given assurance that their participation in the research project would not positively or negatively influence their final mark.

3.3.3 Participants

Participants in this study were six clinical educators and 23 student nurses who enrolled in the Paediatric Nursing Specialist Program. The characteristics of the participants according to their age and duration of being a clinical educator (as identified from the questionnaire in Appendix H and I) are provided in Table 5.

Table 5. Clinical educators' and student nurses' characteristics.

Characteristics	**Participants**	
	Clinical educators (6)	Student nurses (23)
Age range (in years)	36-58	27-50
Duration of the experience as a clinical educator (in years)	8-33	5-17*

*years of experience as educator in their institutions

Amongst the six clinical educators who agreed to participate in the CRP study, two clinical educators graduated from doctoral programs; three clinical educators were paediatric nurse specialists, and one of them had a master degree qualification. One of them was the Vice Dean for Academic Affairs, and one of them was the Head for the Department of Paediatric Nursing. In Indonesia, the term clinical educator refers to someone who work as a supervisor and a resource person for the students in the clinical practice setting. The clinical educator may be a lecturer from the nursing education institution or experienced nurses who works in the hospital. In the CRP study, all the clinical educators were from FoN UI. The reason for this was that there is a very limited number of clinical educators who have a postgraduate degree

background and without a postgraduate degree they are unable to be a clinical educator for this student cohort.

Twenty-three female students who enrolled in the Paediatric Nursing Specialist Program agreed to participate. Five out of 23 students are working as practice nurses as well as clinical educators in a hospital, while the rest are lecturers as well as clinical educators in their academic institutions. The students came from different provinces in Indonesia.

3.4 Data Collection Procedures

Data collected included: 1) field notes; 2) researcher diary; 3) questionnaire; 4) critical discussions; 5) semi-structured interviews; and 6) flash cards. Data were collected from the clinical educators, student nurses and the researcher, and it varied according to the AR cycles. The variability of data sources and data collection time was important to capture the process, the contextual issues and the experiences that were occurring for the participants and the researcher throughout the research process (Brantlinger et al. 2005). A summary of data collected in the CRP study can be seen in Table 6 and are now discussed in detail.

Table 6. Data collection methods.

Data	What data were collected?	What was the purpose of collecting this data?	Who was the resource person?	When were the data collected?		How the data were analysed?
				First AR cycle	Second AR cycle	
Field notes	Notes from observation of the implementation of the CRP model	To document processes, issues and insight during the observation and reflections on the observation	The researcher	✔	✔	
Reseacher diary	Reflections on the implementation of the CRP model	To document any reflections on the implementation of the CRP model	The researcher	✔	✔	Thematic analysis
Questionnaire	Clinical educators' and student nurses' characteristics	To identify characteristics of the participants	Clinical educators and student nurses	✔		
Critical discussion	Clinical educators' and student nurses' reflections	To obtain participants' perspectives and experiences on the use of the CRP model	Clinical educators	✔		Template analysis in the first AR cycle. Thematic analysis in the second AR cycle
			Student nurses	✔	✔	
Semi-structured interview	Clinical educators' and student nurses' reflections	To document and explore the clinical educators' and student nurses' experiences	Clinical educators and student nurses	✔	✔	Template analysis in the first AR cycle. Thematic analysis in the second AR cycle
Flash cards	Student nurses' experiences	To explore the student nurses' experiences and reflections	Student nurses		✔	Thematic analysis

3.4.1 Field notes from observation

According to Montgomery and Bailey (2007), a researcher can have a non-structured written document about anything occurring during an observation and interaction in the data collection period. Writing field notes is considered important to record events occurring during observations (Mulhall 2003). In the CRP study, field notes were used to document notes from observation about my thoughts on what I saw, heard and experienced during the implementation of the model in the clinical practice setting. Observation is a dynamic activity that can capture the whole setting or context in the research process (Mulhall 2003), nonetheless conducting the observations is a challenge due to the presence of the observer which may influence the action of the observed (Turnock & Gibson 2001). In the beginning of data collection, some clinical educators appeared to feel uncomfortable with my presence as they seemed hesitant in contributing to the conversation. At that time I reminded them that I was there to observe the implementation of the CRP model (not their performance), but also to answer their questions related to reflective practice. I noticed that they engaged more over time. In contrast, students seemed to be engaged from the beginning and no differences were noted in their behaviour over time.

Another challenge I experienced in conducting the observation was when I observed something that was not happening in the right way but I was not in a position to say something at the time. For example, when I observed one clinical educator and heard her using questions that may come across as reprimanding the students rather than asking the students to explain the situation. I raised this issue with the clinical educator in the debriefing session and provided her with feedback about the approach she was using and offered her examples of how she may have asked more reflective inquiry questions.

To avoid bias related to personal judgement which may emerge in the observation (Sapsford & Jupp 2006), I wrote what I saw and heard in the field notes and documented my reflections in the researcher diary (this will be explained in the next section and in more detail in Chapter Nine). The observations were conducted once

or twice a week depending on the clinical educators' schedule to supervise the students and they lasted for 2-3 hours at a time. To illustrate, an example of my field notes is provided (Table 7).

Table 7. An example of field notes.

Field notes on supervision process (Tiara) 02/12/2013:	
What did I see?	**What did I think?**
• Tiara conducted her supervision process with seven students. • Ms. Tiara started to ask students about their clinical practice experiences, including the patients' cases. • The students were waiting for their turn to be asked by Ms. Tiara. • Students were sitting quietly, they appear to be listening to Ms. Tiara, and some are nodding to the things she is saying. • Ms. Tiara ended the session asking about students' future plans regarding nursing care plans for the patient. • During the session, Ms. Tiara made limited eye contact with the students, her head was down. She appeared to be writing what the students were saying	Tiara conducted the supervision period in a room which was not conducive for a discussion. I felt uncomfortable as well since I had to sit on a small chair (a chair for a pediatric patient). However, I could see and feel the students' motivation during the supervision period. They really appreciated Tiara since she gave her time (for almost three hours) to have a discussion with the students. In general, the communication during the supervision process was a one-way communication. Tiara asked a question and the student answered. During the discussion, Tiara share her experiences related to what have been told by the students. At the end of the supervision process, Tiara encouraged students to ask questions. As I planned to have a debriefing session with Tiara following the supervision, I discussed with her about the situation in the room and the communication techniques to facilitate students in reflection.

These field notes were written following my observation during Tiara's supervision period on December, 2nd 2013. In the field notes, there were two columns; the left column was a space to write what I saw during the observation and the right column was for writing my thoughts on what I had observed. The field notes were used to support the data found from critical discussions and in-depth interview.

3.4.2 Researcher diary

The quality of AR depends on the sensitivity of the action researcher throughout the AR process (Williamson, Bellman & Webster 2012) and is supported by continuous reflection. This sensitivity begins with recruitment, engagement, data collection, and data analysis, as well as the report writing. From the beginning of the research study I reflected on the various aspects of the AR process until the completion of the writing-up process. The reflection notes were documented in a diary (detailed discussion about my reflection notes can be found in Chapter 9). An example of these reflection notes is provided below.

I realised that I focused more on the reflective writing. In fact, this model is for the whole process of the students' clinical placement. It is perhaps because reflection is a new thing for me as well, or perhaps I still focused on technical matters related to reflection. (Reflection notes: 04/10/13)

In this reflection I described my developing awareness I had regarding the implementation of the CRP model where I only focused on students' ability in writing the reflective report. The reflection process I used was unstructured and depended on what had occurred on that day. I was challenged by this activity as I did not find it easy to write regularly over a long time period. However I continued with this writing process as I believed it would model the process to the participants and I could answer honestly if a participant asked me if I was involved in a regular reflection process.

3.4.3 Questionnaire

Questionnaires were used to obtain descriptive data related to the clinical educators' and student nurses' characteristics, for example age, duration of their supervision experiences and educational background of the clinical educators. The clinical educator questionnaire can be found in Appendix H and student nurse questionnaire in Appendix I.

3.4.4 **Critical discussions**

At the end of the first AR cycle, critical discussions were conducted in the reflection step. The aim of these critical discussions was to obtain participants' perspectives and experiences on the use of the CRP model and the research process. Wong (2008) states that a group discussion is a method that can stimulate thinking and contribution of the participants. Two critical discussions were held for the student nurses and one discussion for the clinical educators. Seven students participated in the first group and eight students in the second group. Whilst, four clinical educators were involved in the critical discussion. The length for each discussion ranged between 50-to-70 minutes.

A guideline to conduct the discussion was prepared before the data collection process commenced. The guideline consisted of issues that should be considered when conducting a critical discussion and a full set of questions (see Appendix J). Examples of questions asked of the clinical educators were: *"What was your experience during the implementation of the clinical reflective practice model and the process used? From your experience as a clinical educator, can you identify any additional types of learning occurring during the reflective process for the students?"* While, for student nurses, the questions were: *"What was your experience during the implementation of the clinical reflective practice model and the process used? What do you think about the reflective activities that you used during the clinical placement?"* In general, the questions were aimed at exploring how the clinical educators and student nurses used reflection in their practice and indentifying areas for improvement in the model.

In the second cycle, four critical discussion sessions were conducted with the student nurses, in order to provide the opportunity for all students to be involved in sharing and reflecting on their experiences following the refinement of the CRP model. The groups were based on their clinical practice settings: surgical, infection, non-infection and perinatology ward. The membership of each group was varied; ranging between three-to-eight students. The length of the critical discussion for the student nurses was between 50-to-90 minutes. An example of the questions being asked

included: *"What was your experience during the implementation of the clinical reflective practice model after the model being revised? What had you obtained from the model? Is there any changes in yourself or your practice?"* In the second AR cycle, there were no critical discussions for the clinical educators since I used individual semi-structured interviews to explore the clinical educators' experiences. The reason for this decision will be described in the next section.

All the critical discussions were audio recorded. The audio recorded interviews were transcribed verbatim. Afterwards, the transcriptions were checked for accuracy by listening to the recorded interviews and reading the transcription at the same time. Differences found between what was in the recorded interview and in the transcription were noted, then changes were made to the transcript. After the checking process was conducted, the analysis process commenced.

3.4.5 **Semi-structured interview**

Following the critical discussions with the participants in the first cycle, three student nurses and one clinical educator were interviewed separately in Bahasa Indonesia. The interviews were held to explore in more detail the information obtained from the discussions. According to McNiff, Lomax and Whitehead (2003), interviews can provide richer data to a research project, since there is an opportunity for the interviewer to explore a topic in more depth during the interview. Examples of the questions asked in the interviews for the clinical educators and student nurses in first AR cycle were: *"What value did you get from the implementation of the reflective practice model? What examples (successes or difficulties stories) of the implementation of the reflective practice model?"*

In the second cycle, a decision was made to interview all clinical educators rather than conducting a further group critical discussion with them. The critical discussion held at the completion of the first cycle did not generate a high level of engagement, some clinical educators lacked focus on the topic and some were talking with one another about other matters during the discussion (detailed discussion about the engagement issue can be found in Chapter Nine). Consequently, they did not fully

participate in the discussion as an important step in the AR process. In addition, the interview format enabled the clinical educators to discuss at length their experiences, identify any concerns and provide solutions or enhancement to the model during the implementation phase of the model without the influence or judgements of their colleagues.

The semi-structured interviews with the clinical educators lasted for 50-80 minutes. A list of the questions asked of the clinical educators were: *"How has this new model assisted you in your role as a clinical educator? Were there aspects of the model that you found challenging or difficult? When reflecting on your practice, what new knowledge have you learnt about your practice as a clinical educator?"*

The interviews were audio recorded and transcribed verbatim. Afterwards, the transcriptions were checked for accuracy by listening to the recorded interviews and reading the transcription at the same time.

3.4.6 **Flash cards**

Creative methods, including photographs on flash cards, can assist with the exploration of different meanings (Patton, Higgs & Smith 2011; Titchen & Horsfall 2011). In the CRP study, a set of flash cards which consisted of a range of photos was used with the student nurses and clinical educators after the clinical placement period was completed in order to gain further insight from the clinical educators and the students.

During an informal session six weeks after they had completed their clinical placement, 21 students were asked to choose a card that captured their experience of using reflective practice. There was a hesitancy at the start of the process which might be due to the influence of Eastern culture dimensions: high power distance and strong uncertainty avoidance. High power distance between the student nurses and me as the researcher might create an uncomfortable situation; while strong uncertainty avoidance could exist since this was their first experience of using the flash card strategy. To reduce the high power distance influence on the students, I also picked a card and started to share my experience. The students quickly

understood the process and actively participated in choosing a card and in sharing their experience with one another. The images in the cards fostered students' insight into their experiences in reflective practice. This session was audio-taped and transcribed verbatim.

3.5 Translation

All data collected during the CRP study, including field notes, the researcher diary, questionnaires, interviews and discussions, were in Bahasa Indonesia, the first language of the clinical educators, the student nurses and myself as the researcher. The translation process was challenging due to the requirements that the data analysis and the results of data analysis must be in English. However, the most challenging part was the translation of data collected from the critical discussion and interviews as it was difficult at times to find the exact words in translation. Santos et al. (2014) recommend that early translation would benefit the researcher to interact with the data more effectively, however, this process comes at a high cost and is time-consuming process (Chen & Boore 2010) and therefore was not always possible in this study. Interestingly, in the evaluation session with the students conducted six weeks after the clinical placement finished, some students used English to explain the flash cards they chose to describe their experiences in reflection during the CRP study. This might be because the presence of my supervisors who did not speak Bahasa Indonesia, and therefore triggered the students to speak in English.

To ensure that during the translation process a change in meaning of the quotes did not occur, two of my colleagues who had their first language as Bahasa Indonesia and had lived and graduated from an English speaking country conducted back-translations. The first colleague was asked to translate some of the quotes that had been selected for use in this thesis from Bahasa Indonesia to English. The second colleague was asked to conduct a back translation of the English quotes into Bahasa Indonesia. Examples of the translation are provided in Table 8.

In general, there were no changes in the meaning of the participants' quotes during the back-translation process, although preferences to use a word in English was different between my colleague and myself in translating the participants' quote from Bahasa Indonesia to English. Similarly, my other colleague preferred to use different word in Bahasa Indonesia to describe a situation as the participants used. For instance, the participant used the word 'berat' which has the same meaning with 'tidak mudah'. I translated the word 'berat' to 'heavy', which has similar meaning with 'difficult'.

Table 8. Examples of back-translation process.

Original quote in Bahasa Indonesia	Literal translation in English	Translation conducted by a colleague	Back-translation conducted by a colleague:
Nah kalau dari segi saya, memang **berat**, sebetulnya saya ini orangnya barangkali orang yang tidak sabaran. Mahasiswa kalau misalnya menjelaskan ini, ini kemudian saya lakukan ini dan seharusnya kan biarkan dulu gitu mahasiswa itu bercerita. Mahasiswa itu nanti ada bagiannya saya yang bertanya.	From my side, it was **heavy**, I actually perhaps an impatient person. If student has to explain this, then I did this and actually I should let the students to tell the story. Later there would be my part to ask.	I personally think it was **difficult**, probably because I am not a patient person. I was supposed to give my student the opportunity to talk about their experience, and then it would be my turn to ask him/ her questions.	Ini **tidak mudah**, karena saya orang yang tidak sabar. Saat mahasiswa menjelaskan sesuatu, saya memotong percakapan. Padahal, saya harus menunggu mahasiswa tersebut untuk menjelaskan ceritanya pada saya karena saya akan mendapat giliran untuk bertanya nanti.
Karena jurnal reflektif itu **sesuai dengan apa keperluan kita**. Apa yang mau kita pelajari kita mencari sendiri, kita tau sendiri, jadi seperti kita lebih mandiri lebih mengetahui keperluan diri kita sendiri.	Because the reflective report **matched our own need**. We looked for what we needed to learn, we learned it by ourselves. So, we were able to identify what our needs were.	Reflective journals were made **based on individual needs**. I myself looked for references that I wanted to know, I learnt myself, and I felt more independent on meeting my own needs.	Karena laporan reflektif **sesuai dengan kebutuhan kami**. Kami mencari apa yang kami butuhkan untuk belajar, kami belajar ini sendiri. Jadi, kami mampu untuk mengidentifikasi apa yang kamu butuhkan.

In order to manage the data analysis in the CRP study (particularly the data from critical discussions and the interviews), the transcripts were maintained in Bahasa Indonesia to avoid the missing meaning that might occur in each transcription. I was more confident doing the analysis in Bahasa Indonesia since a better sense of the meaning of the data was possible in my first language. A transcript was read and the meaning of the transcript content was identified and considered, this resulted in a thorough familiarisation of the transcript content. Once this process was completed the translation process was then commenced. Chen and Boore (2010) also preferred to translate only the categories and concept developed from the data into English to avoid excessive expense and demands on time required. The involvement of my supervisors in the translation process was in ensuring that the translated quotes, categories, sub-themes and themes made sense. In the next section, detailed information about data analysis process will be presented.

3.6 **Data Analysis**

Two different types of data analysis were used in the CRP study namely template analysis and thematic analysis. The rationale for using two different types of analysis was because the aims of data analysis in the first and second AR cycle were different. In the first AR cycle, the data analysis was to identify themes from the clinical educators and student nurses related to the evaluation of the model and the recommendation for the next implementation period. These detailed information could be identified using template analysis. While in the second AR cycle, the themes identified were related to the experience of the clinical educators and student nurses after the model had been revised. Therefore, thematic analysis was the appropriate method to use to identify the experiences.

3.6.1 **Template analysis**

To analyse the qualitative data from the first cycle of AR, a template analysis procedure was employed. This analysis process was focused on identifying a

particular participant's experiences relating to the implementation of the reflective practice model. Template analysis is a qualitative research analysis technique for textual data using highly structured but flexible procedures (King 2012). According to King (2012), an a-prior template is constructed from understandings identified during the literature review and the researcher's existing knowledge. Nonetheless, the initial template is able to be changed during the analysis in response to the emerging findings (King 2012).

The process of template analysis started with reading and re-reading the transcript in Bahasa Indonesia and then coding the transcript using an initial template in English. The template was developed based on the main questions used in the critical discussion and in-depth interviews and findings from the literature review and the researcher's existing knowledge. Two initial templates were prepared one for the clinical educators and the other for the student nurses. The initial template was then modified according to emerging information from the data. The final template was re-applied to the data and all coded-quotes were grouped into sub-themes and themes. Table 9 provided a description of changes in the template for clinical educators' and student nurses' data, and themes identified accordingly.

Table 9. Template analysis for clinical educators' and student nurses' data.

Data	Initial template	Final template
Clinical educators	1. Supervision process 2. Challenges 3. Areas for improvement	1. Supervision process 2. Benefit of reflective practice for students 3. Challenges - Time constraints - Students' conditions 4. Areas for improvement - Nursing round - Frequency of supervision
Student nurses	1. Experiences of reflective practice 2. Reflection process 3. Challenges 4. Clinical educators' roles 5. Areas for improvement	1. Benefit of reflective practice - Finding the rationales - Express feelings - Increased self-awareness - Long lasting knowledge 2. Experiences of reflective practice - Reflection process - Reflection topic - Need a friend 3. Challenges - Writing process - Tiredness 4. Supervision process - Evaluation versus facilitation - Time constraint 5. Areas for improvement - Bed side teaching or nursing round - Group sharing - Increasing the frequency

3.6.2 **Thematic analysis**

Unlike the first cycle of AR, a thematic analysis was used to analyse data collected in the second AR cycle, particularly to explore the experiences of clinical educators and student nurses during the implementation of the revised CRP model. Burnard's thematic analysis procedure (1991) was used as described in Figure 5 which consisted of 14 stages.

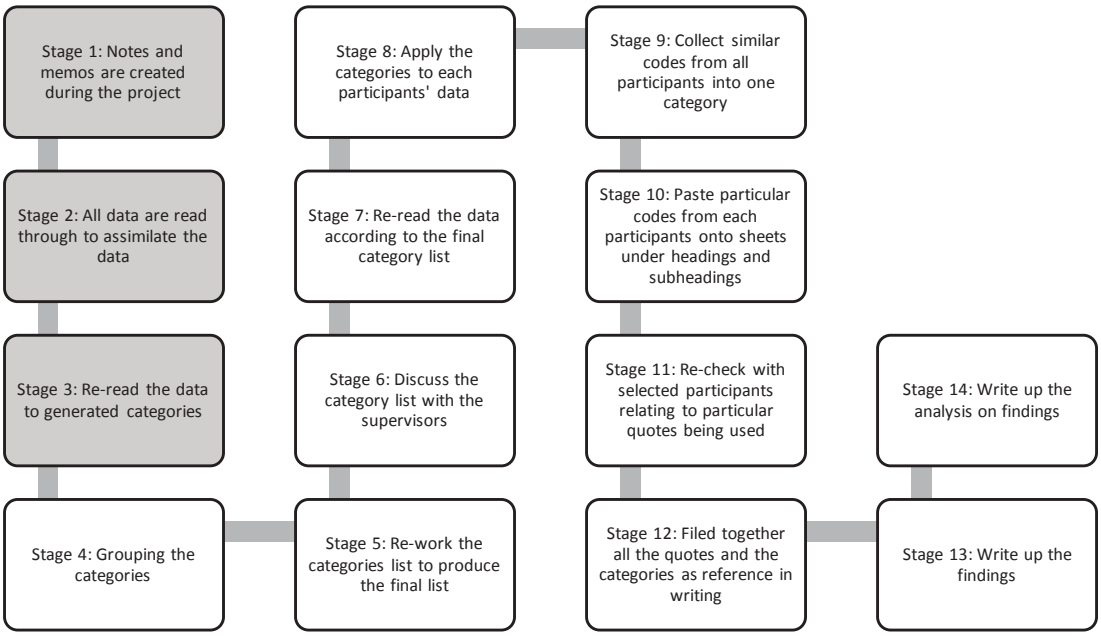

Figure 5. Burnard's analysis procedure

In applying Burnard's procedure, I divided the stages into two according to the language used: stage 1-3 in Bahasa Indonesia and stage 4-14 in English. The purpose for using Bahasa Indonesia in the first three stages was to avoid analysis limitation as recommended by Van Nes et al. (2010) due to a possibility of reduced meaning in the qualitative analysis if it is conducted in another language. When writing notes, as the first stage of data analysis process, Bahasa Indonesia was used. All transcripts from the critical group discussion, in-depth interview and data generated from flash cards were also kept in Bahasa Indonesia. The transcript was read and the meaning of the transcript content was identified and considered, this resulted in a thorough

familiarisation of the transcript content. A memo for each transcript was written at the side of the transcript to indicate meaningful quotes or to reflect on the questions and my questioning technique with the participants. Categories were generated from the meaning of these quotes. At this stage, Bahasa Indonesia was used in the data analysis process.

Subsequently, stage 4-14 in the data analysis procedure (as described in Figure 5) started. To commence stage 4, the categories were translated into English prior to collapsing similar categories together in order to create the final list of categories. This is also the starting point where work commenced with my supervisors, as English is their first language. After the final categorization (in English) was created, it was applied to all of the data (in Bahasa Indonesia). All quotes from participants' data were collected under headings and subheadings. The quotes were translated to English. Finally, the writing up process was commenced.

3.7 **Rigour**

AR is at times criticised as lacking in rigour due to the study being small-scale within a particular setting (Costello 2011). This potentially limits the application of findings in other settings as the ability to generalize to the wider population is difficult or not appropriate. However, ensuring rigour in the research process enables concepts and principles to emerge which can be translated into different context (Tobin & Begley 2004).

This study employed qualitative approaches, according to the language of qualitative research, the term rigour is replaced by trustworthiness (Krefting 1991) which has a similar meaning as validity in traditional research (Rolfe 2006). The trustworthiness of a qualitative study includes four components: credibility, dependability, confirmability, and transferability (Lincoln & Guba 1985). In the CRP study, several strategies had been conducted to ensure the four components of the trustworthiness as can seen in Table 10.

Table 10. Strategies to achieve trustworthiness of the study.

	Credibility	***Dependability***	***Confirmability***	***Transferability***
Prolonged engagement: Regular contact with the clinical educators and student nurses was maintained for 12 and 10 months, respectively.	✓			
Persistent observation: In doing the observation, the clinical setting was visited weekly during the clinical practice period.	✓			
Data triangulation: Data were collected using various strategies such as observation, field notes, critical discussion, semi-structured interview, questionnaire, and flash cards.	✓	✓		
Member checking: Following the data analysis, the participants were provided with the findings and their feedback sought.	✓	✓	✓	
Audit trail: A researcher diary was used to record all the research processes over time and constant reflective conversations with supervisors were used to check evolving assumptions.		✓	✓	✓
Reflexivity: My reflections were recorded in the researcher diary during the research process.	✓	✓	✓	
A thick, vivid description: The research report (this thesis) provides a thick description of the research project.				✓

3.7.1 Credibility

Credibility is an essential criterion for qualitative research as it relates to the truth of findings and their interpretation (Polit & Beck 2014). Further, Reason and Bradbury (2001) emphasize that the process of inquiry in an AR study is as important as the findings. Credibility of the CRP study was achieved using several strategies such as prolonged engagement and persistent observation (as can be seen in Table 10). In the CRP study, I started to engage with the participants in the recruitment process. Observations were conducted to capture the whole picture of the context during the implementation of the model. In doing so, the observation has assisted in enhancing the credibility of the CRP study due to its ability to identify issues that occurred during the implementation of the CRP model (Krefting 1991).

3.7.2 Dependability

Research credibility is difficult to achieve without dependability which refers to the stability of data over time (Polit & Beck 2014). Data triangulation is a strategy to enhance the dependability (Stringer 2007) by using various data collection procedures (such as field notes, critical discussions, semi-structured interviews) and various data sources (such as the clinical educators, student nurses and myself) as described in Table 6. Each of the data collection approaches complement one another in the research (Krefting 1991). This data triangulation was conducted to provide a different view of the phenomena being studied from different perspectives (Curtin & Fossey 2007).

3.7.3 Confirmability

Confirmability refers to the degree to which the findings are shaped and derived from the participants (Lincoln & Guba 1985). One strategy to achieve this was member checking which ensures that the findings come from the data and not from the researcher's imagination (Tobin & Begley 2004). In this study member-checking occurred after themes were identified. Following the identification of themes, I presented the themes from the critical discussions and semi-structured interviews in

the first AR cycle to all clinical educators using a group discussion. These findings were then used to revise the CRP model.

While, in the second AR cycle, a summary of the findings were translated into Bahasa Indonesia. This summary was then sent to the six clinical educators and six student nurses after the CRP study completed (during the thesis writing). Four clinical educators and six student nurses responded and confirmed the congruence of the findings with their experiences in the CRP study.

Reflexivity is also used to ensure the confirmability and refers to the ability of a researcher to explicitly acknowledge that the research setting and the researcher impact on each other (Williamson, Bellman & Webster 2012). As an insider researcher, I had a relationship with the clinical educators and prior knowledge of the student nurses. This relationship had the potential to influence the implementation and findings of the study. Therefore, I tried to be sensitive to all situations in the participants' context by conducting regular reflections and discussions with my supervisors.

3.7.4 Transferability

Transferability is the applicability of the findings to other settings (Polit & Beck 2014) and is determined by the future reader who may obtain detailed information regarding the context or situation of this research. This criterion has been addressed by providing a thick and rich descriptions of the research project, in order to assist the future reader to determine the research context similarities and differences to their own context (Streubert & Carpenter 2011). In this thesis, a description regarding the phenomenon being studied can be found in Chapter One, along with recent literature in Chapter Two. Detailed information about the research process including the rationale or justification of chosen methods and data analysis procedures are provided in this chapter. Activities conducted in the first and second AR cycle are described in Chapter Four, followed by the findings from each AR cycle in Chapter Five-to-Seven. All these chapters can be used by the reader to determine the transferability of the CRP study findings to their own setting.

Another strategy to achieve confirmability in this study was an audit trail (White, Oelke & Friesen 2012). An audit trail is a record of the research process over time, which captures any decision (and rationale) that the researcher makes (Taylor & Francis 2013). To support this, I used a research diary to record the research process and decisions made during the research project.

3.8 Ethical Considerations

According to the Human Research Ethics Committee Policy for Undergraduate and Postgraduate Students, a Doctoral research project requires formal ethics approval (Human Research Ethics Committe 2013). The researcher obtained permission from FoN UI as a study setting and ethical approval from its ethics committee (see Appendix B) before ratification by the UTS HREC (see Appendix C) was undertaken. The ethics approval process was obtained to ensure that the researcher had thought and identified ethical issues and considerations that may occur during the research process. The next section describes the ethical considerations in this research.

3.8.1 Confidentiality and Anonymity

Confidentiality and anonimity may be difficult to achieved in a study conducted in a participant's or researcher's own organization/institution (Streubert & Carpenter 2011). Nonetheless, in this research study the researcher ensured that whilst the clinical educators would know the student nurses who are involved in the critical discussions and in-depth interviews, they would not know the content of what the students were discussing and they would not have access to the data and vice versa.

The data collected were accessible only by my supervisors and myself during the research process. I was not involved in the marking procedure during the students' clinical placement period and therefore no potential negative or positive

consequences on the students' final mark. Furthermore, findings of the CRP study would not be published until all the students had graduated from the study program.

Pseudonyms were assigned to each of the participants, in order to ensure the confidentiality of these data (Orb, Eisenhauer & Wynaden 2001). Using other names dignified the clinical educators and the students more than using assigned number (Seidman 2013). In this thesis, Indonesian traditional names were assigned for the clinical educators, whilst Anglo names were used for the students. This approach was used to increase the ease of reading and as a way of differentiating the quotes from the clinical educators and student nurses.

3.8.2 Information Sheet and Consent Form

A concern that was explored in the recruitment process related to the collectivism cultural characteristics was the possibility that the clinical educators' and student nurses might believe that they must participate, as the aim of the CRP study was for the improvement of the students' learning. I had emphasized in the beginning of the recruitment process that their involvement in this study was voluntary. They did not have to be involved using the CRP model to improve the students' learning if they did not want to.

An information sheet was provided that outlined the purpose of research, the data collection procedures, and participants' rights during the research process. The information sheet covered the benefits and potential risks participants might experience from the research. This information sheet was written in Bahasa Indonesia and English (see Appendix D-G) and was given to potential participants to ensure that they had a comprehensive understanding about their involvement in the research.

All participants voluntarily took part in the research after providing written consent in the first meeting before the collection of data commenced. Participants were able to withdraw at any stage of the study without any consequences. No participants withdrew from this study. Moreover, in the first meeting, they were informed that during the CRP model implementation, I would be in the clinical practice setting as

an observer and a resource person to ask about reflective practice or reflection, and not as an educator. Consent was also provided to allow me to access their reflective reports. Consent was reconfirmed with the clinical educators and student nurses prior to critical group discussions and in-depth interviews.

3.8.3 Data management and storage

According to the Australian Code for the Responsible Conduct of Research, research data management must consider four important aspects: storage, retention, disposal, and access.

In this research study, there were two kinds of collected data: soft files (in the form of computer and audio-taped files) and printed document (such as reflective entries, field notes, and interview transcriptions). Soft file data were entered onto a computer with a password-protected directory. Meanwhile, all printed sources of information were kept in a locked and secure filing cabinet. To prevent data loss, data backups occurred by regularly copying all the data into other appropriate secure storage devices; an external hard disk and a compact disc.

All research data will be securely held for a minimum of five years after the completion of the study including publication of results. This is consistent with the guidelines from the Australian Code for the Responsible Conduct of Research (National Health and Medical Research Council 2007) and the HREC Guidelines for Undergraduate and Postgraduate Students.

After five years, the research data will be securely disposed of to ensure that there can be no access to confidential data and to prevent data from being retrieved by unauthorised persons. The researcher and her supervisors are the only people who have access to all types of research data, both soft file and printed documents. Nevertheless, participants were able to access de-identified data during member checking as part of the data analysis process. All data related to participants was deidentified using another names.

3.8.4 **Potential Risks**

This CRP study was about the development and implementation of a new model of clinical education based on reflective practice in a Paediatric Nursing Specialist Program in Indonesia. There were changes occurring as a result of the implementation of the CRP model that were identified as potential risks, such as changes in the frequency of supervision or in the assignment format. The CRP model required the clinical educators to conduct supervision regularly in order to facilitate the students' reflective capacity development. This potentially altered the supervision schedule prepared by the clinical educator prior to implementation. During the study, all clinical educators had no objection with what was required by the model, even though in reality the clinical educators sometimes could not regularly provide supervision for the students.

From the student nurses' perspectives, the assignment format was changed to a reflective report. This could create for the students' feelings of uncertainty. In regard to this potential risk, a syllabus containing information about the assignment format was provided for the students before the clinical placement commenced. Examples of reflective reports were also provided for the students.

The main potential CRP study risk was the reflective process which required the participants to explore their clinical actions and the outcomes of these actions. This was mitigated by providing numerous avenues for the clinical educators and the students to reflect and feedback throughout the study. All the clinical educators and the students accepted the changes in the clinical practice model. During the data collection period, they were provided with regular Research News Update (Appendix K) which provided information about the research process and what was required to implement the CRP model. All of the strategies above were conducted in order to apply the application of non-maleficence principle.

Above all, the study provided benefits for the clinical educators and student nurses in term of providing the opportunity to gain an enhanced practice experience as a clinical educator and an improved clinical learning process for the student nurses.

When the clinical educators and student nurses gained this benefit, this means that beneficence as one of the ethical principles had been considered thoughtfully.

3.9 Summary

Action research was chosen as the research approach for this study because of three reasons: it enables the facilitation of reflective practice; it aims to improve practice in a particular setting; and it increases equality in the social context. The CRP study aimed to introduce a clinical model to Indonesian clinical educators and students that integrated reflection in their clinical practice. Indeed, reflection itself is inherent in an AR cycle, therefore AR has a direct link to reflective practice.

This chapter provided detailed information regarding the context of the CRP study, data collection and data analysis procedures. The study was conducted in Indonesia which used Bahasa Indonesia as the first language to communicate with others. As an outcome a translation process was a necessary part of the research process. In addition, rigour and ethical considerations were also presented in this chapter. The next chapter will provide information about the first and second AR cycle process.

Riset Aksi dipilih sebagai pendekatan yang digunakan dalam penelitian ini berdasarkan tiga alasan yaitu RA mampu memfasilitasi praktik reflektif, RA bertujuan untuk memperbaiki praktik, dan membantu mengatasi masalah terkait kesenjangan masalah sosial. Penelitian ini bertujuan untuk mengembangkan dan mengimplementasikan model klinik baru kepada pembimbing klinik dan mahasiswa keperawatan di Indonesia, yang mengintegrasikan refleksi dalam praktik keperawatan mereka. Refleksi itu sendiri menjadi komponen utama dalam RA, oleh karena itu RA memiliki hubungan langsung pada praktik reflektif.

Bab ini memberikan penjelasan detil terkait konteks penelitian RA ini, proses pengumpulan data dan prosedur analisis data, sekaligus proses menterjemahkan hasil

penelitian dikarenakan penelitian ini dilakukan di Indonesia yang menggunakan Bahasa Indonesia sebagai bahasa utama untuk berkomunikasi dengan orang lain. Sebagai tambahan, rigor dan pertimbangan etik juga diberikan dalam bab ini. Bab selanjutnya akan berisi deskripsi siklus pertama dan kedua dari RA.

4 Action Research Cycles

4.1 Introduction

The purpose of this study was to implement a Clinical Reflective Practice (CRP) model designed to integrate Indonesian cultural characteristics with reflective practice principles. In the previous chapter I provided details of the research design and methodology used in this study. This chapter provides a description of the first and second AR cycle and begins by outlining what happened during the phases of plan, action, observation and reflection.

4.2 First AR Cycle (July-December 2013)

4.2.1 Plan phase

One of the main characteristics of AR is to involve participants in the research process (Zuber-Skerritt & Perry 2002), in order to trigger the change process. There were two groups of participants involved in the CRP study, the clinical educators and the student nurses who were enrolled in the Paediatric Nursing Specialist Program. Engaging the clinical educators was considered important prior to starting the implementation process, as they were one of the key enablers in developing and implementing the CRP model. The clinical educators agreed to make adjustments to their current practice; it was anticipated that this would facilitate changes in the students' clinical practice and impact on the students' development (Reilly 2007).

4.2.1.1 *Engagement with clinical educators to develop the model*

From the beginning of the research process, clinical educators were involved in refining and finalizing the CRP model. This process was achieved through several

workshops that drew on the clinical educators' knowledge and experiences. In the workshops, several areas were explored including: reflective practice concepts; the processes involved; the difficulties in implementing a model of reflective practice; and strategies to be used by clinical educators to facilitate reflective practice in the clinical setting. Indonesian cultural characteristics and differences with Western countries, particularly related to the education setting, were also discussed. Having knowledge about reflective practice and Eastern cultural characteristics were important in order to shape the CRP model for Indonesian students.

The clinical educators shared examples of Indonesian culture characteristics that they experienced during the learning process which included power distance, collectivist and stronger uncertainty avoidance. The examples were aligned with Hofstede, Hofstede and Minkov's (2010) description of culture dimensions. Of note, the clinical educators and I considered that masculinity had limited if any influence in the implementation of the new model due to the homogeneity of gender in the study.

Building on our joint understanding, we confirmed the feasibility and appropriateness of the proposed model to the Paediatric Nursing Specialist curriculum. At the end of the first meeting, it was agreed that this model would replace the previous model used for clinical placement, which did not contain any reflective activities. This outcome enabled this research project to be integrated into the curriculum. The benefit of this decision for the students was that they were not required to undertake additional work beyond their student assignment.

Another activity to engage clinical educators was the development of the syllabus for the three clinical practice subjects that were used in the CRP model. Unfortunately, this component of the engagement strategy was not as successful as anticipated. The clinical educators insisted that I was the right person to modify the syllabus due to my prior knowledge about the curriculum and experiences as a clinical educator. They argued that I knew more about reflective practice compared to their knowledge level. In fact, I had imagined this situation before I started the data collection process as a consequence of being an insider research. To deal with this situation, I offered an agreement that I would modify the syllabus by integrating the CRP model, but we

would finalize it together. All clinical educators agreed with this proposed approach. I believed that it was important to give a clear expectation for the clinical educators that their involvement in the CRP study was as important as my role as the researcher. This was a learning experience for them and they were encouraged to actively engage in the research process.

Another factor that impacted on the engagement of clinical educators during the plan phase was their limited availability due to their busy workloads. Reminders were regularly needed that this CRP study was not only about my research needs, but more importantly to improve the clinical learning process for the students. These reminders were delivered to increase the ownership of the study from the clinical educators' perspective. The ownership of a study might relate to participants' engagement in the research process itself (Cronin & Connolly 2007). One aspect that assisted overcoming some of these difficulties was my position as the researcher and 'being in the middle position' amongst my colleagues. Being in the middle means that I acted as a bridge and thus I was able to negotiate and communicate with senior lecturers and less experienced lecturers as a means of reducing the effect of high power distance. An individual approach was also used to increase the clinical educators' awareness of the importance of their engagement in improving the learning process.

An individual approach was identified as potentially reducing interpersonal sensitivity that frequently occurs in a collectivist society (Kapoor et al. 2003). This was the most successful strategy in engaging the clinical educators. By having a one-on-one discussion, their concerns were identified in regard to the research process and the model we had developed. This approach seemed to minimize the influence of the collectivist approach amongst the clinical educators; as during an individual discussion the clinical educator did not have to be concerned about what they were saying in front of each other (Kuswandono 2014; Wanda, Wilson & Fowler 2014).

4.2.1.2 *Engagement with student nurses*

Meanwhile, different approaches were used to engage the student nurses in this study. The students were provided with information on how reflective practice might

benefit their learning process during the clinical placement period. During the information session, their questions were answered about how this clinical learning experience might be different to their previous experiences, including information about assessment in the CRP model. These questions were not surprising as it is common in an educational setting that students are assessment-driven (Laverty 2012), and likely to be more focused on how to fulfil the assessment rather than the learning process itself. I anticipated that if they realized the potential of the CRP model to assist their learning process during the clinical placement period they would become more engaged and involved in the implementation process.

I needed to take into account that the students are part of a collectivist society, where people have a tendency to do what they are expected to do (Triandis 1995). My response in this case, was to consider the cultural characteristics in developing the model to minimize high power distance in order to support the students to engage in the project without them feeling they had to participate.

4.2.1.3 *The Clinical Reflective Practice Model*

The outcome of the plan phase was the finalisation of the CRP model. The model was developed based on the values underpinning reflective practice and by taking into account Indonesian cultural characteristics. This section provides a description of the CRP model and the key component, structured reflection, will be explained. A structured reflection process was developed based on Gibbs's Reflective Cycle (Gibbs 1988) and contextualized according to Indonesian culture. Student nurses were encouraged to use the structured reflection in anticipation that it would assist them to minimize strong uncertainty avoidance which has the potential to occur because of insecure feelings due to the uncertainty of the situation. Hofstede (2011) argues that a society that supports strong uncertainty avoidance, such as in Indonesia, prefers a structured way of learning. Indonesian students are likely to experience insecure feeling when they have to face an uncertain or a new situation. Providing an example of what should be contained in the reflective report was anticipated to assist the student minimize their insecure feelings.

In the structured reflection template, as can be seen in Figure 6, students were asked to describe an event they had experienced in the clinical setting, then analyse the event from three perspectives: self, others (such as patients, families, staff) and their knowledge. Afterwards, a future action in a similar situation was planned. Examples of how students used this template are provided in the next section.

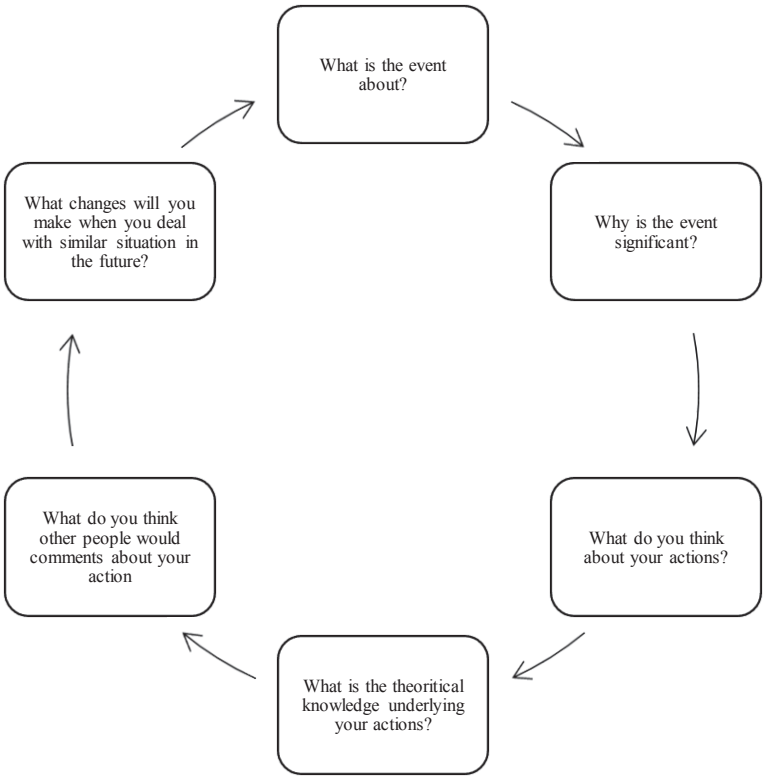

Figure 6. The structured reflection

The structured reflection template provided a guide for the students to assist in learning to reflect on their clinical practice. This structured template could also be used as the template to write their reflective report. Furthermore, the structured reflection template provided a basic framework for the CRP model. As can be seen in Figure 7, the CRP model consisted of two stages: preparation and implementation process.

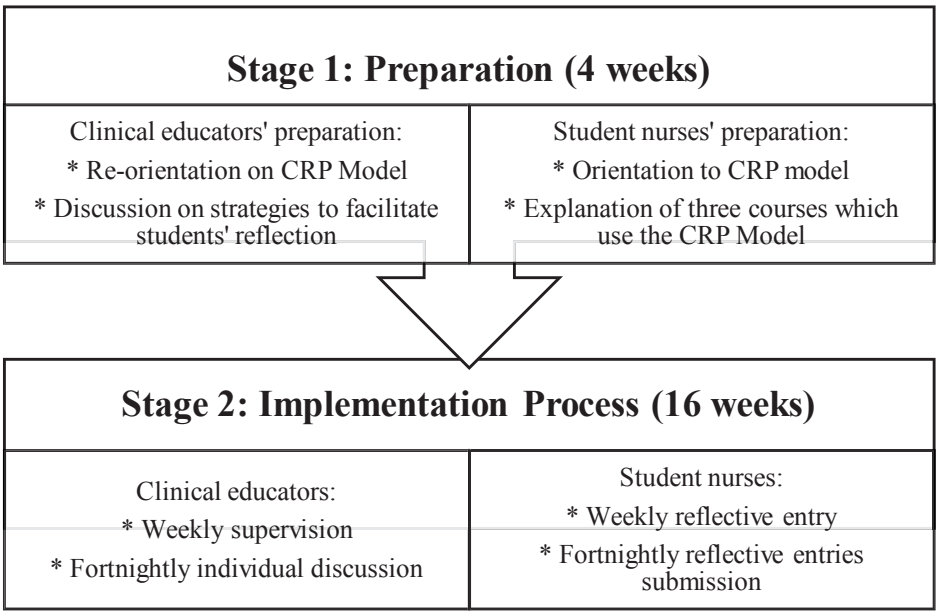

Figure 7. The Clinical Reflective Practice Model

Providing a preparation program for clinical educators prior to the clinical practice period was essential in assisting to facilitate a successful clinical experiences for students (Gaberson, Oermann & Shellenbarger 2014). The aim of this preparation session was to clarify the clinical educators' and student nurses' understanding of the CRP model. Then, during the implementation process the student nurses were asked to write a reflective report using the structured template as in Figure 7 and submit it fortnightly to their clinical educator. The clinical educators were encouraged to create a schedule to conduct individual discussion with the students to discuss their reflective entries. The individual discussion approach was chosen in order to to overcome cultural characteristics including collectivist and high power distance. One-on-one discussions allowed the students to think about themselves and their own learning needs. It was also anticipated that the relationship between the clinical educator and the student would become less formal during a one-on-one discussion. The students were encouraged to express and explore their clinical experiences and the reflections they had shared in their reflective report.

4.2.2 **Action phase**

This section consists of a description of what occurred in the preparation (Stage 1) and implementation process (Stage 2) of the CRP model in the first AR cycle. Changes to the model or the research process that were made during the implementation of the CRP model are also discussed.

4.2.2.1 ***Stage 1 - Preparation***

In the preparation stage, orientation sessions for clinical educators and student nurses were provided to discuss reflective practice and issues related to reflective practice. From the clinical educators' perspective, the preparation stage was conducted as a means of creating a shared understanding about the CRP model. This 2-hour preparation session aimed to provide the clinical educators with increased confidence in using the model (Gaberson, Oermann & Shellenbarger 2014). Of note, some of the students enrolled in this program were older and likely to have more experience in clinical practice than the clinical educators. This age and experience differences potentially influenced the clinical educators' confidence level. It was identified as important to prepare the clinical educators for the role as the facilitator in the CRP model in order to boost their confidence level. In the preparation session, we discussed the three nursing subject syllabuses which employed the CRP model. At that time, not many questions were asked. It appeared that the clinical educators had enough information about the CRP model.

From the students' point of view, the preparation session acted as a beginning phase for them to learn about reflective practice. Twenty-three students who agreed to participate in the CRP study attended the preparation session. In the session, the subject coordinator explained reflective practice and the new model of clinical practice that would be implemented during their clinical placement period. This session was conducted one month prior to the clinical placement period. In contrast to the situation with the clinical educators' in the preparation stage, student nurses asked many questions about reflection during their preparation session. In general, the students asked about how to conduct a reflection and how to write a reflective

report. This might be an indicator of strong uncertainty avoidance in the students since they would experience a new model and this condition potentially triggered insecure feelings within the students due to having to deal with a new situation.

4.2.2.2 *Stage 2 - Implementation Process*

In implementing the clinical reflective practice model in the first AR cycle, the clinical educators and student nurses worked with me for 16 weeks. There were three important considerations that needed to be managed. The first was the clinical educators' responsibility to ensure that student nurses obtained the best possible clinical experiences during their clinical placement period. The second was the students' requirement to engage with the clinical reflective practice model for a set period of time and to submit the required assignments related to the model. The final consideration was my role as a facilitator and observer during the implementation of the model. To be a facilitator meant that I had to be available for the clinical educators and students during the model implementation period when they needed to clarify or discuss something about reflective practice or using the model. In addition, observations were conducted of the clinical educators and students; as observation, in many instances, are able to capture the whole setting of the CRP model implementation (Mulhall 2003).

In the first week of clinical practice, a Research News Update information sheet was distributed to the clinical educators to remind them about the implementation of the model and strategies they might use in conducting reflective discussions. In the following weeks, other Research News Updates were distributed according to the needs of the clinical educator group. Most of the updates highlighted strategies to facilitate reflective practice during the clinical placement.

Besides the Research News Updates the clinical educators were also provided with debriefing sessions following each observation in the clinical setting to maintain their interest in reflective practice. Most of the time, they asked for feedback in relation to what they had done. They wanted to know if it was 'good or not'; and requested confirmation that their activities fitted with '*my*' research objective. This seemed to indicate that they were feeling unsure and did not feel a sense of

ownership over the research or the process of implementing the model. These debriefing sessions were used to assist the clinical educators to reflect on their actions during the supervision period. In some discussions, information was provided about: what was needed to be done or changed to improve the model. For example, two clinical educators indicated that they did not know how to assist students to reflect on their actions related to patient care. I discussed this with them and provided information on how to use reflective questioning techniques in the next Research News Update.

The strategies used with the student nurses to maintain their involvement in this study were slightly different to those used with the clinical educators. In week 12 of the CRP model implementation, the students were invited to participate in a group discussion about their experiences thus far and barriers they had encountered. The idea to have a discussion on this topic was due to the clinical educators reporting that many students had not submitted their assignments on time. Not all students attended the group discussion; however students who came were able to share their experiences. Generally, the students discussed the benefit they had gained from using reflection. Nonetheless, they were challenged on how to conduct a reflection and write the reflective report. Voicing these challenges triggered a discussion about the reflective process and the development of a reflective report. A few weeks after that, I visited students in their clinical settings and observed their practice and took the opportunity to discuss with the student their progress. In short, several strategies were used in the first AR cycle to facilitate changes within the clinical educators and student nurses such as distributing Research News Update, having individual debriefing sessions with the clinical educators and conducting informal group discussions with the student nurses.

Despite the students' positive experiences of engagement in reflective practice, the change of practice by the clinical educators during the implementation process phase was slow and not as I had expected. They limited their visits to the hospital setting despite having previously agreed to a weekly supervision schedule. This might have been explained as being due to their heavy workloads in the faculty. Since I had experienced a similar situation a few years ago, I was able to accept the situation and

the reason they gave for the schedule changes. As a result, I did not initially challenge the clinical educators. This seemed to be the best strategy to use in this kind of situation in order to 'save face' of the clinical educators when they found themselves in an uncomfortable situation (Chiang, Chapman & Elder 2010). It is a common practice in Indonesia, as one of the countries that have high power distance, to not confront people that are respected in order to avoid humiliating the person. In this case, I respected the clinical educators as my participants and my colleagues. Moreover, I was influenced by the collectivist concept which paid more attention to ensure the group's (clinical educators') continuing interest (Hofstede, Hofstede & Minkov 2010).

To assist the student nurses a small technical change, which was allowing the students to choose to use or not to use the structured template provided when writing their reflective report, took place during the implementation of the CRP model. This change occurred despite the clinical educators' encouragement to stick with using a structured template and was taken in order to support and facilitate students who had difficulties in following the structured template. Examples of how students used this structured reflection template in writing their reflective report are provided below. Some parts of the reflective report have been translated to describe how the students used the reflection template. In the first example, the student used headings in writing the report, following the template provided. Meanwhile, the second example demonstrated a free writing style even though the student still used the structured reflection template to guide her in writing the reflection.

First example of the student report with a structured format:

> *Description: Fluid intake and output monitoring in a non-infectious paediatric ward was written in a form provided in the ward and a nurse filled in the form. Information about the total amount of fluid intake and output was obtained from the parents. The parents took notes about the time, fluid intake amount and total urine output. The parents took notes in their own book…*
>
> *Analysis: I think intake and output monitoring by the parents really helped nurses. This did not dispute family-centered care principles, because parents*

were involved in the care for their child. However, the monitoring notes need a standard and 'easy to use' form so the parents can do the note taking appropriately…

Theoretical background: Shepherd (2011) provides an example of accurate monitoring in fluid intake and output. This monitoring is conducted hourly. The type of fluid intake is also written clearly and accurate. The nurse's role in this case are fluid balance monitoring regularly and accurately…

Plan of actions: 1) to create an easy and informative form; 2) to feel confident in doing the monitoring…

In the first example, the student used headings from the structured reflection template provided. In contrast, in the second example, the student wrote the reflective report with unstructured format.

I wrote this reflective journal aimed to exercise myself being an advocate to the patient. It was about giving breast-milk to an infant…

A situation occurred when I was giving care to a 1-month-infant. This infant was scheduled to have a fluid intake when she is getting better. The doctor had scheduled to give her the formula. I asked the doctor: What was the reason the infant had to have the formula? Did the parents know about this plan? The doctor answered that she had not told the parents yet, and usually the parents would agree with this decision…

When the parents visit the ward, I asked them: What did they give to the infant so far? The parents said breast-milk. Then I told them about the plan to give a formula to their infant. The mother said that she would like to give only breast-milk to her baby. After I discussed with the parents, I told the doctor that the infant's mother would like to give only breast-milk to her baby…

I did this for the infant's benefit because having breast-milk from a mother is the infant's right… From that situation, I learned that I had to be brave to do something for the patient's benefit.

4.2.3 Observation phase

During the implementation phase, observations were conducted in order to understand how this model worked in action. Kemmis and McTaggart (1988) states that through observation, a researcher is able to capture the meaning of what is occurring as a result of an action. In the first contact with the clinical educators, they raised their concern about what would happen during the observation and I was aware that they felt uncomfortable being observed. The Indonesian cultural characteristic of high power distance may have had an influence in creating these feelings of discomfort, whereby the clinical educators' usual position (higher) was influenced by being observed perhaps positioning them at a lower status level. To try and reduce their discomfort, I tried to limit any intrusion during the observation, as I understood my presence might cause the clinical educator to be reminded about my role as the observer. I would not say anything or become involved in the discussion. Prior to each supervision session commencing, I emphasized that I was there as their partner, not as their assessor.

The aim for conducting the observation of the CRP model implementation into the clinical practice setting was to capture the situation as it occurred. Notes were made about: what I heard, what I saw, and what language was used in the conversation. The length of each observation was varied, ranging between 50-to-120 minutes. The duration depended on how many students were being supervised by a clinical educator at that time. I conducted ten observations of the clinical educators (minimum of one per educator) in the first implementation period of the CRP model.

4.2.4 Reflection phase

Reflection as the final phase in Kemmis and McTaggart's AR cycle is used to evaluate the process and any issues found in the action (Kemmis & McTaggart

1988). In this study, clinical educators and student nurses reflected on the CRP model, as well as, the process they participated in during the implementation of the model. Reflection as the last phase in an AR cycle was used to collect data from clinical educators and student nurses about the CRP model implementation through group critical discussion or indepth interview. The following description details these reflection sessions for the clinical educators and student nurses.

A reflection session for clinical educators was held four weeks before the clinical placement period ended. Two weeks before I conducted the reflection session, an invitation was distributed for the clinical educators to attend the critical discussion. To accommodate their busy workload, two alternative times were provided for them to participate in the critical discussion or an interview. Four out of the six clinical educators were able to attend the critical discussion, while one educator preferred to be interviewed individually. However, one educator could not find the time to be interviewed or attend the critical discussion.

Concurrently, a reflection session for student nurses was also conducted before the first clinical placement was completed. An invitation was sent to the students to participate in the critical discussion or interview. To meet the needs of the students, two critical discussions (consisted of six and eight students) and three individual interviews were conducted. Seventeen of the 23 students participated in the reflection sessions. Themes and sub-themes that arose through the reflection phase are outlined in Chapter Five. Findings from the reflection phase became the basis for the CRP model revision. The revision of the model was the starting moment in the re-plan phase during the second AR cycle.

4.3 Second AR Cycle (February-June 2014)

4.3.1 Re-Plan phase

The findings from the clinical educators and student nurses during the reflection session indicated a need to refine the CRP model and the structured template for the students' reflection. The refinement made to the structure of students' reflection template was aimed at facilitating and supporting students to reflect on their experiences during the second clinical placement period. The structured reflection would potentially assist students in writing their reflective reports. In addition, the students' learning process was also changed to facilitate improved clinical experiences.

4.3.1.1 *The Revised Clinical Reflective Practice Model*

The structured reflection template used in the second AR cycle was named the 5Ds (as can be seen in Figure 8), which consisted of a specific process of thinking.

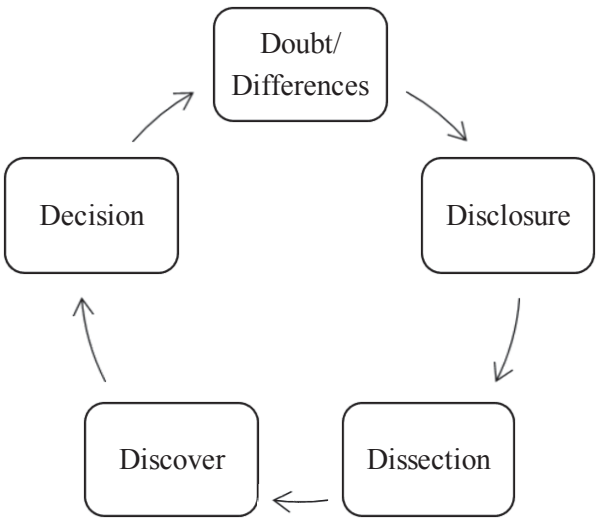

Figure 8. The 5Ds structured reflection

The order of the thinking process for the student was as follow:

- ***D****oubt/differences* - Start with, did you find any doubt in your practice? Or did you spot any differences in what you had done in the clinical setting with what you had found in the literature? Write in a simple sentence, just like a topic title.
- ***D****isclosure* - Write about the situation or experiences you had regarding the topic you mentioned above. Please make it simple and provide only the description related to the topic.
- ***D****issection* - Write your analysis and consider several aspects such as: why did it happen?; what was the impact of the situation or experiences for you or other people involved?
- ***D****iscover* - Following your analysis, find additional information from the literature to support your analysis and discussion of the topic.
- ***D****ecision* - In this section, you will write your plan for the future, what would you do if you found yourself in a similar situation?

The difference between this structured template and the previous structured template is the guidance provided to the students from the beginning of the process to choose an experience where they are experiencing doubt or identifying a difference with what they already know. This might assist in reducing one of the challenges they had of being confused about how to use their practice experience with the CRP model. Furthermore, this new structured template focused on students as an individual. During the first AR cycle, the students were aware that they had to learn new knowledge and skills according to their own needs. In other words, the students were reconstructing their thinking – they no longer had to think that the interests of the group were more important than their interests as an individual.

In conjunction with the refinement of the structured reflection, the revised CRP model based on the findings from the clinical educators and student nurses can be seen in Figure 9. Two main points (in bold and italics) were added to the clinical reflective practice model: a group reflective discussion and a new template to support the students' reflective report writing.

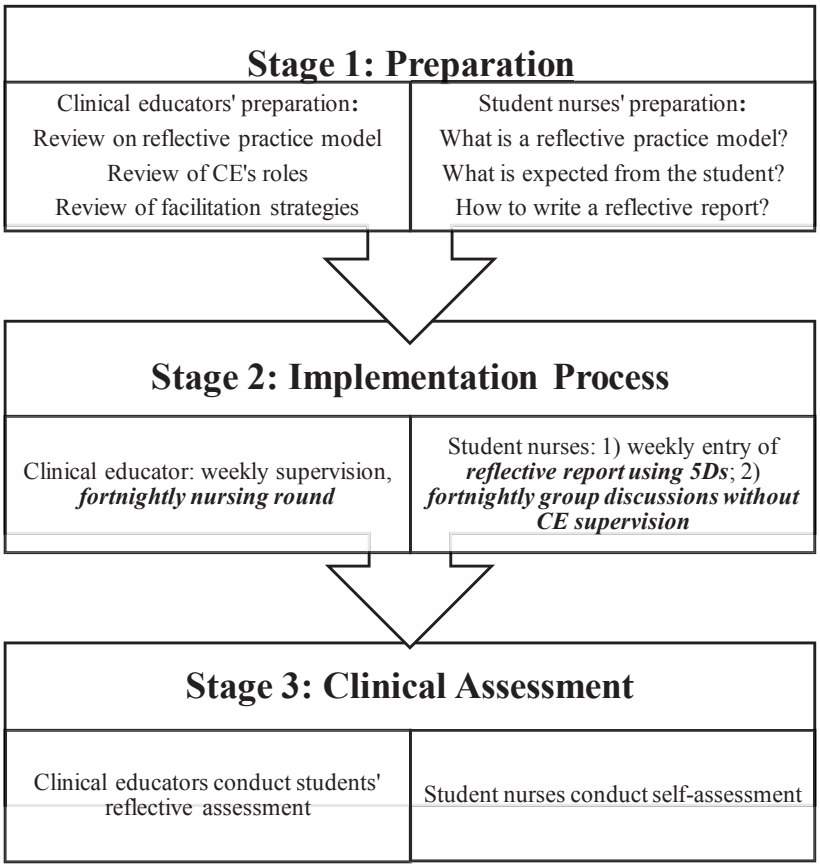

Figure 9. The Revised Clinical Reflective Practice model

The main challenge for the clinical educators in the first AR cycle was time management, as they found it difficult to undertake supervision on a regular basis. One strategy to overcome this problem was to employ a group discussion approach. The original idea for a group reflective discussion was provided by the clinical educators as a means of enabling a group of the students to learn at their own pace without waiting for the clinical educators' visits. This had additional outcomes that students might learn from being exposed to other students' perspectives during the group discussion (Cronin & Connolly 2007) which in turn enriches the students' learning (Wen et al. 2015). This approach also had potential benefits for the students when the clinical educators had limited time to conduct the supervision sessions. The students agreed to have a student-led group discussion fortnightly. Between that time, the students expected the clinical educators to come to the clinical setting to conduct their individual supervision and to provide them with time to clarify matters they had discussed during the student-led discussions.

4.3.2 **Action phase**

In the second AR cycle, the aim of the preparation stage was to refresh students', as well as clinical educators' knowledge about reflective practice and the revised CRP model. A discussion about facilitation strategies was also conducted with the clinical educators. In the second AR cycle, I had at least one debriefing session with each clinical educator following their supervision process. Similar to the first AR cycle, Research News Updates were distributed for the clinical educators and student nurses. Five Research News Updates were distributed to the clinical educators and three Research News Update for the student nurses. Some of the topics covered in the Research News Updates for clinical educators included reflective questioning techniques and behaviours of effective clinical educators. The clinical educators increased their supervision frequency with the students in response to feedback in the first cycle of the study which indicated a lack of clinical educators visits as a problem.

Several group discussion sessions were conducted in the ward with the students to provide them with direct facilitation to support their reflection on practice. I sometimes facilitated these discussions with the students when the clinical educators were unavailable. The students preference was usually to discuss the writing of their reflective report using the new 5Ds structured template. An example of a student report using 5Ds' structured reflection template is provided below.

> *Doubt: I felt guilty because I could not give parenteral nutrition to a newborn as required.*
>
> *Disclosure: Baby N, born 23rd of February, 2014 hospitalized in Special Nursery Care 4, is scheduled to have parenteral nutrition therapy for 8 days. However, the therapy cannot be administered because there was no syringe pump in the ward...*
>
> *Dissection: The therapy cannot be administered because of limited instruments. I tried to ask for it but it was unsuccessful. The limited*

instruments occurred because the bed occupation ratio was 120%, therefore the nurses had to prioritize the use of syringe pump in the ward...

Discover: One of the nurse's role in giving care to neonates is assisting the neonates in the adaptation process by applying the conservation energy theory. Parenteral nutrition therapy is important for the neonates in certain condition such as...

Decision: If I have to deal with the same situation again, I will: 1) try to fulfil the newborn's nutrition need using the available instruments or 2) if it cannot be conducted, I will monitor closely the effect of the situation to the neonate.

4.3.3 Observation phase

Due to the clinical educators increasing their visits to the students in the clinical settings to conduct the supervision, observations were again conducted to capture more in-depth and rich information about how the clinical educators and student nurses were implementing the CRP model. A total of ten observations were conducted with each observation lasting for more than one hour.

4.3.4 Reflection phase

On completion of the implementation of the CRP model, reflection sessions were conducted separately for the clinical educators and student nurses. Individual interviews were also held to facilitate the clinical educators' ability to reflect on their practice using the CRP model. While, for the students, critical discussions were used as a means to support students to reflect on their clinical practice experience. Four student sessions of critical discussion were held in the varying clinical practice settings: surgical ward, neonatal ward, infectious ward and non-infectious ward. The total number of students for each group varied from three-to-eight students. Additionally, one student had her clinical practice in a paediatric intensive care unit. For this reason, an individual interview was conducted with her. A further evaluation session group was conducted with the students six weeks after the clinical placement

was completed to explore the benefits of using reflective practice during the clinical placement.

4.4 Summary

The first AR cycle focused on development of the CRP model, followed by the implementation and evaluation of the model. This first cycle was conducted over a six-month period, which consisted of plan, action, observation and reflection steps. In the plan phase, strategies were used to engage the clinical educators and student nurses in the CRP study. The outcome of this step was the CRP model, which was then introduced during the student nurses' clinical placement. This was when the action and observation steps were held. The last step in the first AR cycle was reflection. Critical discussions and in-depth interviews were employed to facilitate clinical educators' and student nurses' reflections. Themes and sub-themes were identified during the reflection step in first AR cycle and will be presented in Chapter Five.

Similarly, four steps had taken place in the second AR cycle. The second cycle started with a re-plan phase where the CRP model was refined, then followed by the action (implementation of the revised model) and observation steps. The final step was the reflection session when the clinical educators and student nurses shared their experiences in using the CRP model and during the CRP study. Findings related to the second AR cycle can be found in Chapter Six.

Siklus pertama dari RA ini berfokus pada pengembangan model PiKiR, yang diikuti oleh implementasi dan evaluasi model. Siklus pertama ini dilakukan selama periode enam bulan, yang terdiri dari tahap perencanaan, aksi, observasi, dan refleksi. Di tahap perencanaan, berbagai strategi telah diaplikasikan untuk melibatkan pembimbing klinik dan mahasiswa keperawatan dalam penelitian ini. Hasil dari tahap ini adalah model PiKiR, yang diaplikasikan selama mahasiswa praktik klinik.

Saat inilah dimana tahap aksi dan observasi dilaksanakan. Tahap akhir dalam siklus pertama RA ini adalah refleksi. Diskusi kritis dan wawancara mendalam digunakan untuk memfasilitasi pembimbing klinik dan mahasiswa dalam berefleksi. Tema dan sub-tema yang muncul dari tahap refleksi di siklus pertama RA ini akan dijelaskan pada Bab Lima.

Hal yang sama juga terjadi pada siklus RA yang kedua, dimana siklus ini juga terdiri dari empat tahap. Siklus dua ini dimulai dengan tahap perencanaan ulang, dimana model PiKiR ini diperbaiki, yang selanjutnya diikuti oleh tahap aksi dan observasi. Tahap terakhir adalah refleksi, disaat pembimbing klinik dan mahasiswa berbagi pengalaman mereka menggunakan model PiKiR dan selama penelitian berlangsung. Temuan yang berkaitan dengan siklus kedua RA akan dijelaskan pada Bab Enam.

5 Findings from First AR Cycle

5.1 Introduction

This chapter outlines findings from first AR cycle using data collected and analysed from reflection sessions held at the end of the first AR cycle, which was conducted two weeks prior to the first clinical placement period being completed. Two strategies, critical discussions and in-depth interviews, were used in the reflection session. Critical discussions were held prior to in-depth interviews. The reflection sessions for clinical educators and student nurses were conducted separately in order to avoid the high power distance influences occurring between the clinical educators and the student nurses.

Data were analysed separately and the findings will be presented from the perspective of the clinical educators and student nurses. Excerpt from field notes will be used to support the findings. Four themes were identified for the clinical educators' data and five themes were identified in the student nurses' data. In order to differentiate the clinical educators and the students easily, Indonesian names will be used for the clinical educators, while Anglo names are used for the students. A summary of findings will conclude this chapter.

5.2 Clinical Educators

Clinical educators shared their experiences using the CRP model during the students' first semester clinical placement. They discussed strategies they used in the CRP model and suggested improvements that could be made prior to the next implementation period. In addition, they shared their observations regarding what had occurred with the students after the implementation of the model. Four themes were identified: varied strategies used; towards self-development; avoiding

behaviour; and areas for improvement. An outline of themes and sub-themes from the clinical educators can be seen in Figure 10. Findings are presented with quotes from the clinical educators used to illustrate the themes and related sub-themes.

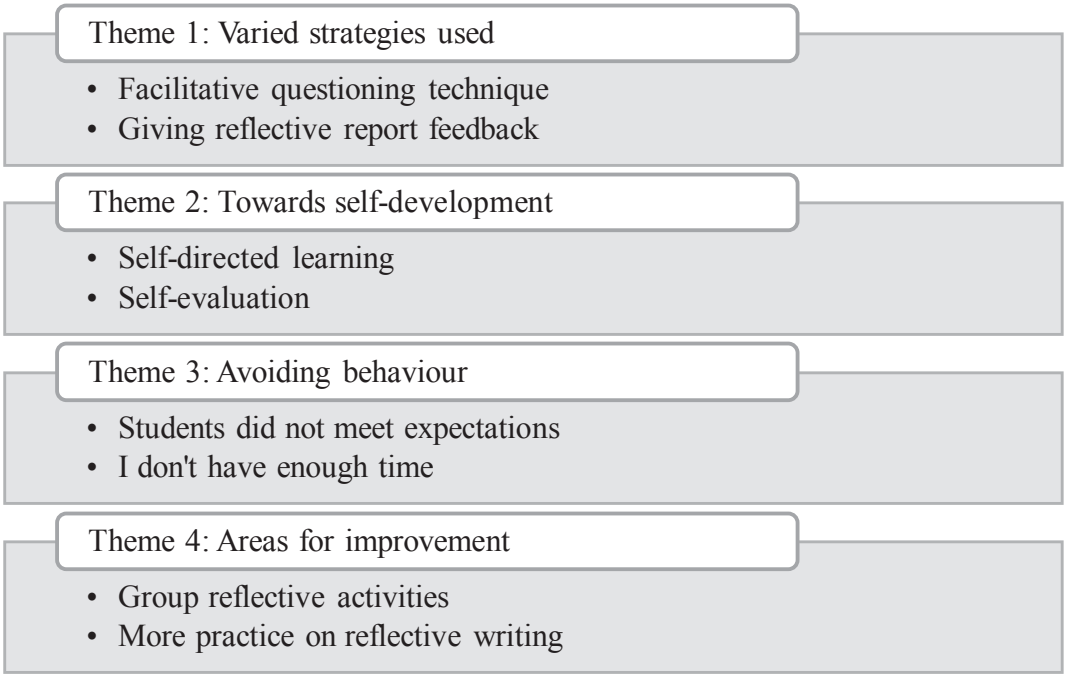

Figure 10. Clinical educators' themes and sub-themes in the first AR

5.2.1 **Theme 1: Varied strategies used**

The CRP model developed with the involvement of the clinical educators was used during the students clinical placements with the clinical educators having responsibility for conducting the supervision process. This process included learning activities where the clinical educators would assess a student's learning achievement according to the clinical target[5] that had been pre-determined by them before the clinical placement began. During the supervision process, they might ask the student

[5] Clinical target is a list of clinical cases and clinical procedures which has been set for the students to achieve during their clinical placement period.

several questions in order to explore what the students had achieved and what area need to be improved. The clinical educators were also responsible for reading the students' reports which were submitted to them fortnightly.

The clinical educators used various strategies during the clinical placement period including individual or group discussions. The discussion could be located in an available room in the clinical setting or in front of the patient. In the discussion they used facilitative questioning technique to explore students' achievement. For example *so, tell me about what have you learned so far?* This was an open-ended question and it was an appropriate starting point for a discussion with the students.

Besides the facilitative questioning technique, they also provided feedback on the students' reflective report. According to the CRP model, the students were expected to submit a reflective report to the clinical educator fortnightly. Following the feedback on the reflective report, the clinical educators had to return the report and discuss it with the student. These two main strategies, using facilitative questioning technique and giving feedback on reflective report, (as can be seen in Figure 11) are now discussed in more detail.

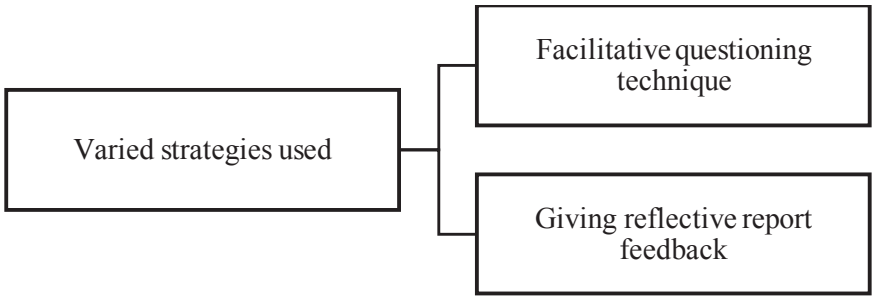

Figure 11. Theme 1: Varied strategies used and its sub-themes

5.2.1.1 ***Facilitative questioning technique***

Almost all clinical educators mentioned that they used questioning to identify if the students had achieved their clinical target. The clinical target was the clinical cases and clinical procedures that students had to engage with during the clinical placement period. Facilitative questioning technique was used to explore the learning

process and the learning achieved by the students following a clinical procedure performance.

> *During discussion with the students, I started by asking questions about what they had obtained from clinical practice and reflective report.* (Putri-CE)

> *When the student finished the procedure, we had a discussion. I asked her to tell me what she had done.* (Maharani-CE)

From the above quotes, the clinical educators started the supervision process by asking students some investigatory questions and then followed by encouraging the students to discuss their responses. This approach was used to explore with the students their achievements so far. Putri's quote described that she focused more on the clinical target that students must achieve during the clinical placement period as stated in the syllabus. This may be an example of strong uncertainty avoidance application where the clinical educator preferred to focus on something that has a standard to compare with, in this case referred to the clinical target list determined before the clinical placement started. Sekar illustrates the types of questions she used in order to obtain detail information about the clinical target.

> *Do you think that you have achieved all the targets? How do you achieve the targets? I focused on the competencies, whether they had achieved it or not.* (Sekar-CE)

The use of facilitative questions was captured during the supervision process where I observed that the clinical educators used open-ended questions as an ice-breaking strategy. For example, they asked students: *what have you done so far?*[6] or *please tell me about your patient*[7]. An open-ended question was an effective way to commence a discussion as it provided the student with an opportunity to expand their

[6] Field notes on supervision process (Tiara) 30/09/2013

[7] Field notes on supervision process (Sekar) 23/09/2013

response. The clinical educators acknowledged that following the open-ended questions, they ask the student for more specific detail related to the patient care, as described in the conversation with a student in the ward as reproduced here:

> *Ayu: What is the problem with the patient?*
>
> *Student: Not many, mam, because the client*[8] *will be discharged soon.*
>
> *Ayu: You cleaned her* [the patient] *skin. What is that for?*
>
> *Student: Oh yes. There is a risk of impaired skin integrity.*
>
> *Ayu: Why does a premature baby have that problem? Can you tell me her skin condition? Do you remember about skin tissue, right?*
>
> *Student: I remember, mam. It is epidermis.*
>
> *Ayu: Yes. What does epidermis look like?*
>
> *And so on…*

Ayu continued her questioning about detailed information on a patient case. Indeed, she said that:

> *Yes, I'd like them to be like that* [answering detailed questions]. (Ayu-CE)

From Ayu's story, it can be seen that she used facilitative questioning technique to obtain more detailed information from the student about her knowledge of one topic. However, the more specific and detailed questions the clinical educators asked resulted in an increased possibility that the student could not answer the questions. This might be related to the high power distance dimension (as mentioned in Chapter One), where the clinical educator is the person who is positioned as knowing everything and they are recognised as having a higherlevel (of knowledge) than the students.

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[8] In Indonesian educational setting, the word 'client' is preferably used than 'patient'. However, in this thesis, the word 'patient' is used due to its general meaning in nursing and other health discipline.

In brief, the facilitative questioning technique was used by the clinical educators for several reasons: to start a discussion as an open-ended question, to identify students' achievement and to explore the knowledge that the students had about a topic.

5.2.1.2 *Giving reflective report feedback*

Feedback as an educational strategy is an important activity used to support the students' development. This strategy was used by the clinical educators during supervision in this study to provide the students with feedback about their reflective report.

> *So, I was focusing on how they wrote reflective reports and I gave feedback on that.* (Sekar-CE)

> *In the first weeks, I tried to focus on students' reflective reports. I tried to compare their reports to the guidelines provided.* (Ayu-CE)

From these quotes it appears that the clinical educators focused more on reflective writing skills and feedback was given on how the students wrote their report, rather than what they were writing about. Feedback was also provided to prompt students' critical thinking.

> *I gave feedback, asking them to do deep analysing, using 'why' question, and the students were expected to answer the questions in the report.* (Ayu-CE)

> *I gave her* [the student] *written feedback. I said "This would be better if you analyse this, and this, and this."* (Sekar-CE)

Ayu and Sekar use two different approaches of giving feedback. Ayu asked the students to use *'why' question* in order to facilitate their ability to think critically in their reflections. While, Sekar provided direct and specific feedback as to how the students could improve the analysis component of their reflections. In her next quote, Sekar goes on to provide more information related to her approach to giving feedback.

Giving a written feedback is a challenge. I frequently felt that I need to meet the student individually after that. Yet, there was time limitation. So, I just hope that my written feedback could make her think. (Sekar-CE)

Sekar indicates that she did not have enough time to explain her feedback individually to the students. She implies that her written feedback may not be sufficient to make the student think. There is also a level of frustration about not being able to meet with the student because of time limits.

It can be seen from the data that the clinical educators used a couple of strategies to engage with the students. Firstly, through the use of questioning undertaken during direct supervision, and secondly, providing feedback on reflective reports which generally were undertaken in a written format.

5.2.2 **Theme 2: Towards self-development**

The clinical educators shared their perspectives about the benefit students gained from their engagement with reflective practice. According to the educators, the students developed both competence and capacity as nurses in the clinical setting. Reflective activities in the CRP model facilitated the students to think about themselves in order to learn according to their own needs. Self-development might be achieved due to the increasing opportunity for the students to participate in self-directed learning, followed by self-evaluation. Self-directed learning and self-evaluation (sub-themes as outlined in figure 12) which were conducted through reflection, could be combined as a learning cycle for the students. The outcome of this learning cycle may result in students being self-directed to develop the capacity to be competent nurses.

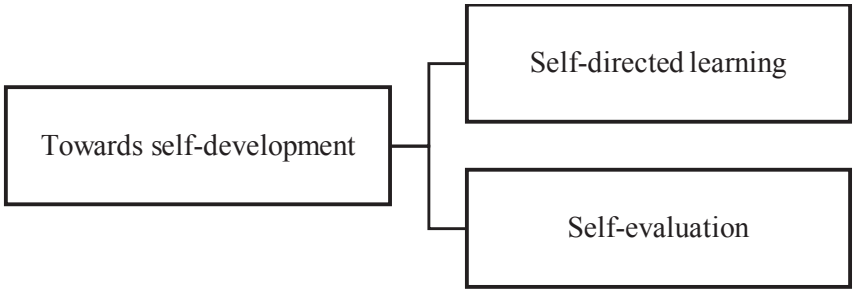

Figure 12. Theme 2: Towards self-development and its sub-themes

5.2.2.1 ***Self-directed learning***

Almost all clinical educators acknowledged that the CRP model assisted students to learn from their own clinical experiences.

> *They were good in identifying something to be learned more.* (Maharani-CE)

Maharani indicates that the students themselves were able to decide what they needed to learn more about and this enabled them to become more self-directed in their learning. Indeed, the students were interested to learn more than the clinical educators had expected of them.

> *Then she* [the student] *said that the situation* [an experience that the student just had] *was good to be written in her reflective report. This means that she was aware that she needed to learn more about that situation. I didn't ask her to do that.* (Maharani-CE)

Maharani emphasized that the student had identified her own learning needs without waiting for her instruction as would have generally been the approach used in previous clinical placements, with the clinical educators driving the student learning goals. She was surprised by the student's reaction to the situation. Another educator Tiara reported that students broaden their attention during clinical practice as illustrated in the quote below.

> *One more thing, with this reflective report, I can see that students had a wider thought. It was not only about physical problems of the patient. They*

> *learned parents' behaviour, parents' response, children's behaviour, so not only physical problems.* (Tiara-CE)

Tiara indicates the differences in the students' learning and their growing ability to focus not only on the physical problems but also on the social emotional issues that are occurring for the child and the family. It was clear that students using the CRP model were developing their own sense of self-directed learning and were using their clinical experiences as motivation to expand their learning and knowledge.

5.2.2.2 ***Self-evaluation***

The clinical educators also noticed that the reflective practice model had a positive impact on the students' ability to evaluate their own performance during their clinical practice period. A clinical educator provided examples of how students evaluated their own clinical performance.

> *...the student started to think that in order to fulfill the need of fluid* [of a patient]*, she has to assess what is occurring at the moment and what should be prepared for the future.* (Maharani-CE)

Maharani described that the student was demonstrating an increasing ability to prepare herself for future actions according to the reflection she had on her clinical practice experiences. In this following quote, Maharani provides another example of a student's self-evaluation.

> *Perhaps NICU environment made her* [the student] *nervous, so she felt not confident. She was aware she was not confident. So she did something. She tried to find other people to teach her. I asked her "What did you do for your previous patient?"* [The student replied] *"I could do it, but I am not confident here." This means that she could evaluate herself and tried to increase her confidence by gaining help from others.* (Maharani-CE)

Whilst the student lacked confidence to practice in the NICU, Maharani considered this as a positive learning experience:

> *I see it as a positive aspect in terms of her ability to evaluate herself. This means that she is aware that not everyone can practice in level 3. Therefore, she needed supervision. This also means that she was aware of her skills, so she had to prepare herself to be better.* (Maharani-CE)

Putri another clinical educator indicated that the CRP model gave students a different experience increasing their ability in conducting self-evaluation. Indeed, Putri acknowledged that self-evaluation was not a part of the student learning process prior to the implementation of the CRP model.

> *The students said that through reflection, they were able to evaluate themselves. Previously, we never gave opportunities to the students to evaluate their own progress.* (Putri-CE)

The above quotes clearly demonstrates that the CRP model triggered and supported the development of the students' reflective capacity, including how they can plan for future action. In the following quote the clinical educator highlighted that for students who actively reflected on their practice, there is an ongoing benefit.

> *With this method, what the student gets can be used to explain what occurs this week and what are next.* (Putri-CE)

In the structured reflection template, the students were asked to plan for future action according to their previous experience. This was one of the new abilities the students gained from using the CRP model. By having a plan for their next action, the students are preparing for the next learning activities. In other words, the students learn from their evaluation, and they evaluate why they learn. This may describe how the CRP model assists in students' self-development.

5.2.3 **Theme 3: Avoiding behavior**

The development of the CRP model involved the clinical educators in order to engage them with the action research process and raise their awareness about the CRP model and the role the clinical educator plays in the clinical learning process. However, the clinical educators interpreted the role of this new model as predominately supporting the student nurses' learning and less about themselves. They frequently seemed unaware of their responsibility to facilitate and encourage the students in developing their skills in reflective practice. They referred to the students' characteristics or conditions that restricted the effectiveness of the CRP model (students not meeting expectations) and identified that they did not having enough time to conduct supervision due to their high workload as a faculty member (see sub-themes outlined in Figure 13).

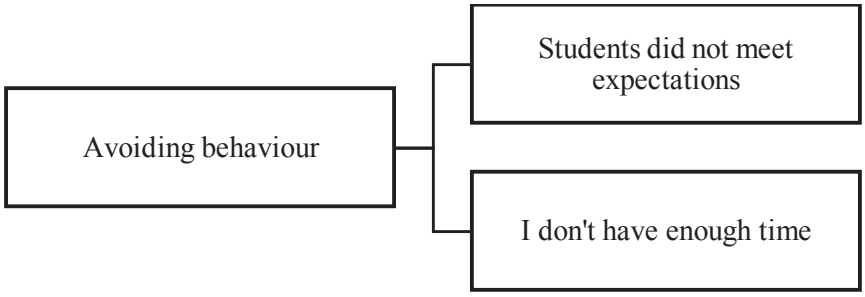

Figure 13. Theme 3: Avoiding behaviour and its sub-themes

5.2.3.1 ***Students did not meet expectations***

Clinical educators criticized some students who did not perform well during the clinical practice period or who could not answer questions asked by the clinical educators. In the following quotes both strengths and deficits of the students are provided:

> *For certain students, their motivation to learn was so obvious. They observed something and linked it to the literature. Yet, not all students are like that. There were some* [students]*...not as motivated as other students.* (Sekar-CE)

> *Like what I have told you before. She* [the student] *thought that her learning process was okay, but I found out she missed something such as why the patient is not like this or like that.* (Tiara-CE)

Sekar identifies that some students' motivation to learn is obvious. She then counters this with her observation that other students lack this motivation. Tiara added that a student was overestimating her performance in the clinical setting. Both of these quotes demonstrate that students did not always meet the clinical educators' expectation during the clinical practice period according to what had been set as the clinical target in the beginning of the clinical placement period.

In the following quote another clinical educator shares her disappointment that the students are not meeting her expectations:

> *In fact, I hoped that students were not only giving a description* [in the reflective report]*, but the analysis and the future plan. That's what I expected from them. In the beginning, they only gave me description. For their next reports, they were trying to make changes, particularly in the analysis section. But maybe we as the supervisor asked too much. So as their supervisor, I did not satisfy with their reports. The analysis section needed to be improved.* (Ayu-CE)

Ayu expected that the students would provide a more critical reflective report. However, according to her standard in assessing the students' report, the students were not critical enough in their report. Furthermore, Putri identified a similar situation that is a lack of an important nursing skill – *analysing the case.* Yet she did not provide any further information about how to improve the student nurses skills.

> *At one hand, they faced difficulty in the analysis section. Indeed, our students were weak in analysing the case when it was occurring.* (Putri-CE)

In her quote, Putri highlighted the most challenging part for the students in writing their report was the analysis section. In general, the clinical educator's responsibility after they receive students' reports was to give feedback on the content of the report

related to nursing knowledge and the writing style. From an observation session on how a clinical educator gave written feedback to students' report[9], I found that feedback was given by asking some questions to facilitate the student to think further, while another clinical educator gave some words as hints to clarify what the students meant in the report. Examples of questions used by a clinical educator included: *can you discuss growth and development theory in relation to the child's trauma*[10] and *how would you evaluate your actions?*[11] as a way of establishing if the students had more in-depth knowledge about the topic.

5.2.3.2 ***I don't have enough time***

Another aspect that potentially hindered the supervision process was the time constraints identified by the clinical educators. All clinical educators claimed that they were overloaded with the work required by the faculty. As a result, they indicated they could not come to the hospital to conduct supervision on a regular basis or indeed to review the reflective reports. The clinical educators were expected to conduct the supervision process once a week, however in reality they came to the clinical practice setting fortnightly, or if they had extra time, they came twice in a week in order to subtitute a week they did not come. Regarding reviewing students' reports, the clinical educators were expected to return the report to the students a week after they submitted it. Most of the time, it took more than two weeks to return the report. Interestingly, one of the clinical educator did return the students' report back in less than a week, but this only occurred in the beginning weeks of the CRP model implementation period. The next two quotes describe the clinical educators' time limitation.

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[9] Field notes on Tiara (27/09/13) and Sekar (10/10/13)

[10] Field notes on Sekar (17/10/13)

[11] Field notes on Ayu (16/11/13)

> *...but I had to do many things lately so I couldn't see it* [students' reflective report]. (Tiara-CE)

> *I did not have time to read their reports. I only had a chance to read the reports twice* [in the beginning weeks]. (Ayu-CE)

Both clinical educators described how their workload impacted on the time available to read the reports. While other clinical educators raised the issue that they were unable to provide the students with optimal level of supervision as an outcome of them not being available every week within the clinical setting.

> *The supervision could not be done optimally,* [because] *we could not come every week.* (Sekar-CE)

> *...the limitation was we didn't give intensive feedback...* (Putri-CE)

Time limitations are acknowledged by the clinical educators as one of their problems resulting in a lack of intensive supervision or feedback for the students. From the clinical educators' perspective that their expectations of the students were not fully met. However it was clear that the time they had available to provide direct and in-direct supervision for the students was inadequate resulting in avoiding behaviour. This limited supervision time can be argued as impacting on the students' use of the model. In regards to this problem, the clinical educators discussed strategies that might address these issues and indicated areas for improvement.

5.2.4 **Theme 4: Areas for improvement**

Apart from the experiences they had during the implementation of the CRP model, the clinical educators agreed that some areas needed to be improved before the second clinical placement began. It took a significant period during the discussion to identify the changes needed in the CRP model, this may have been due to the different perspectives emerging from the clinical educators. They agreed to focus on

two changes which were: introducing group reflective activities and more practice in reflective writing (see Figure 14) . Group reflective activities were regarded as appropriate to be implemented in the second clinical placement to ensure the students' learning process was supported to become more efficient. The students' ability in writing reflective reports also required improvement.

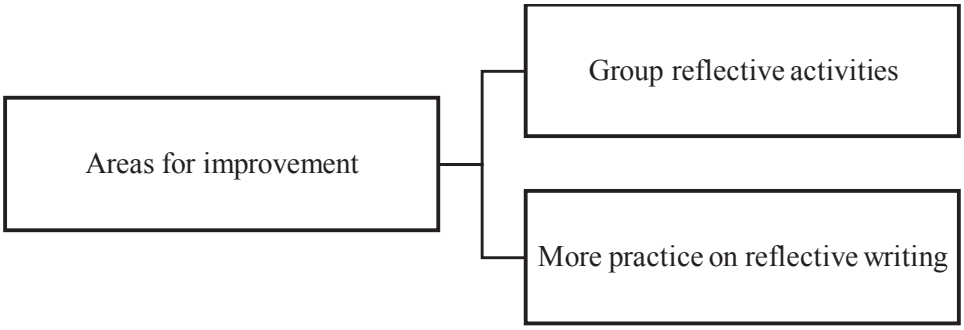

Figure 14. Theme 4: Areas for improvement and its sub-themes

5.2.4.1 ***Group reflective activities***

Before the first clinical placement period commenced, the clinical educators agreed that two senior clinical educators would conduct nursing rounds, while the other four clinical educators would be responsible for conducting regular individual reflective discussions. However individual reflective discussion had occurred for only a limited time in the beginning period of the CRP model implementation. For the second clinical placement period, four clinical educators identified they would like to use group reflective activities in the form of a nursing round as a means of implementing the supervision process.

> *I think that's what they expect from us, because when I did an individual supervision, a student approached me, I asked her "What are you doing here? Do you want to listen to our discussion?"* [The student replied] *"Yes, mam, if you allowed me to do that."* [Then I said] *"Okay, you can listen to us."* (Ayu-CE)

Ayu described a situation where she was conducting an individual supervision session for a student and at the same time another student asked her permission to

listen to the discussion. In her quote, Ayu emphasized that the students preferred to have group activities rather than individual discussion. I observed a similar situation occurring in the clinical practice setting, where the students preferred to ask the clinical educators to discuss the patient case in a group.[12] Additionally, Maharani gives another perspective of group reflective activities.

> *I also think that students need to have the nursing round… because I think each patient case will be different, result in different questions being asked and the discussion takes a longer time. This will not happen in individual discussion.* (Maharani-CE)

In her quote, Maharani said group learning might provide more learning experiences for the students to compare to their individual learning. It was noted that participating in group learning would take a longer time period. In fact, not all clinical educators agreed to use nursing round because of the longer time needed as well as the uncomfortable feeling of conducting a discussion in front of the patient, as described by Tiara who already used nursing round once during the CRP model implementation.

> *I had* [conducted nursing round] *once, but it took long time to finish. The family and the patient were there, I could sense the uncomfortable feelings from the patient. The uncomfortable feelings also came from the long time we took to do that, almost 2 hours or more. As a result, the time to fulfil the patient's needs was also distracted.* (Tiara-CE)

Beside group activities requiring a longer time allocation, another aspect that impeded Tiara from conducting nursing round was her own uncomfortable feeling.

> *Perhaps, personally, I was influenced by an uncomfortable feeling when discussing something using medical terms* [in front of the patient and the family]. *That's what made me uncomfortable.* (Tiara-CE)

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[12] Field notes on Maharani (13/11/2013)

Tiara continued to share her disapproval of the nursing round activities which she indicated was due to the use of medical terms in front of the patient and family. This was perhaps because she felt the family would not understand what was being discussed. Another clinical educator raised an issue related to what the students were or were not doing in the nursing round activities.

> *In one side, the positive one, they* [students] *get more knowledge since the patient cases are varied, but on the other side, what I am afraid of, they try to avoid their tasks in the ward.* (Putri-CE)

In spite of the benefits the clinical educators could see that students would gain from the group activities, there was concern about the time needed to conduct nursing rounds and the impact this may have on the students' responsibilities to care for the patients on the ward. If the students were involved in a nursing round for one-to-two hours, then other nurses, instead of the students, had to provide nursing care to the patients. This might not be appropriate or safe nursing practice from the clinical setting perspective. At the end of the session, the clinical educators agreed that nursing rounds would be applied in the second clinical placement. This was identified as beneficial for the students. The clinical educators needed to contain the time spent on the nursing round to ensure it was not taking the students away from patient care for long periods of time.

5.2.4.2 ***More practice on reflective writing***

The positive outcome captured in the reflection was the clinical educators' self-critique of their skills as educators and the ways they could be further supporting the students learning. They identified that more practice in writing the reflections were needed in order to develop the students' writing skill. The clinical educators took some responsibility for improving the situation as they also suggested that more attention was required in assisting the students increase their skills in writing reflective reports.

> *I think we need to enhance their skills in reflective writing. I am afraid that they don't understand.* (Maharani-CE)

> *...need to practice or how to write before we expect them to do that, it will be better I think.* (Sekar-CE)

Enhancing the students' skills in reflective writing was considered a necessary inclusion in the model to increase the clarity of how to conduct a reflection and how to write the reflective reports.

> *Yes,* [we can see] *whether students increased their knowledge or not from their written report, not only from the discussion… I was afraid that they didn't have the ability to write it in the report. Perhaps, the knowledge increased already but it was not well written.* (Sekar-CE)

Sekar raised an issue that the main problem faced by the student is lack of writing skills. If clarity in the report cannot be achieved, then the clinical educator is less likely to be able to assess the students appropriately. The clinical educators suggest that the students must have a practice session about how to write reflective report before the second clinical placement period.

In brief, the clinical educators recommended two changes in the CRP model in order to improve implementation: group reflective activities (being mindful of the time involved and not taking the students away from practice area for a prolonged period) and a practice session for the students to write the reflective report.

The clinical educators were in the beginning stage of accepting of the model. They could see some positive changes in the students. Despite that, not all clinical educators were fully supportive of the model. This may have been related to the changes that they had to make around their roles and they way they conducted sessions with the students. They identified some recommendations which were then applied in the second clinical placement.

5.3 **Student Nurses**

The student nurses were more eager to share their stories related to the implementation of the CRP model compared to the clinical educators. Most of the students were actively engaged in the reflection session where they discussed their experiences of using the CRP model, including the benefits they received and the challenges they found with the implementation of the model. They also readily offered suggestions in order to improve the implementation of the CRP model.

Data collected and analysed from the students' perspective identified five themes: making sense of reflective practice; positive impacts; struggling with the writing process; uncertainty in supervision; and supervision needs to be improved. A visualization of themes and the related sub-themes can be seen in Figure 15.

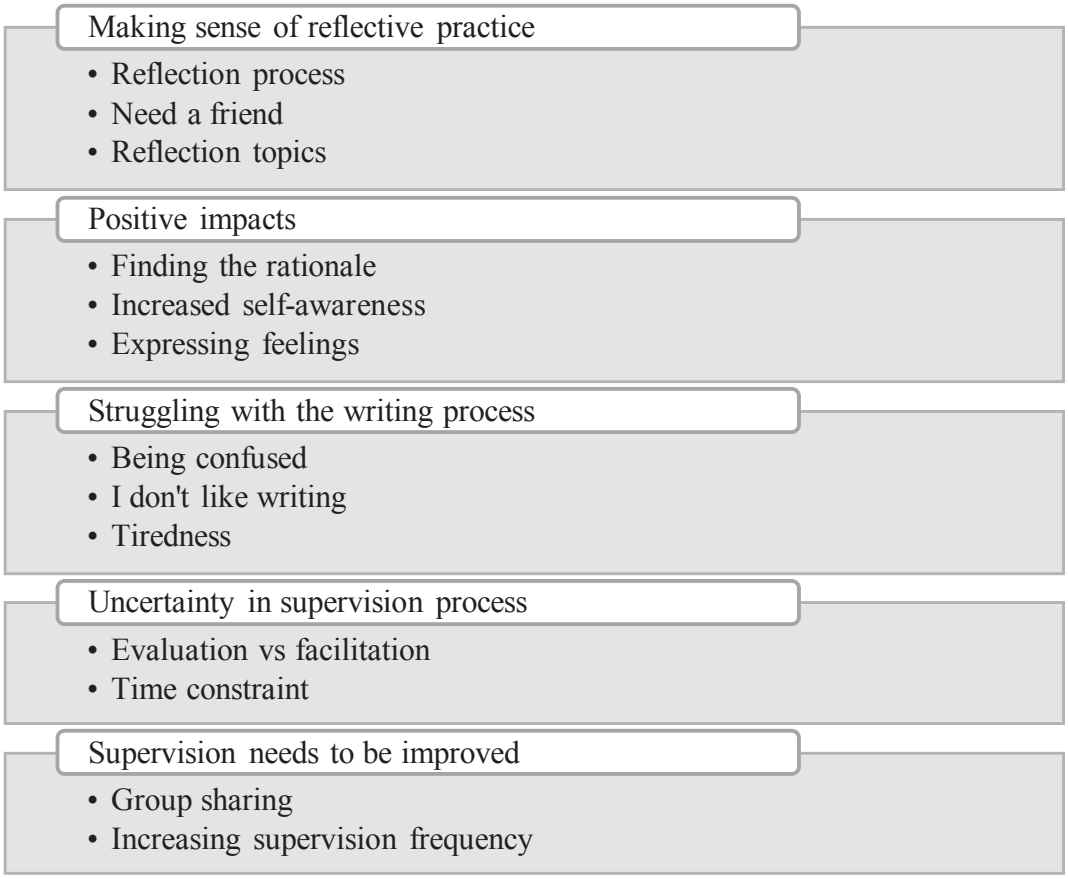

Figure 15. Student nurses' themes and sub-themes in the first AR

5.3.1 **Theme 1: Making sense of reflective practice**

Almost all of the students had no prior experience in reflective practice and most had never even heard the term reflective practice. In the preparation session, the students were eager to know about reflective practice. However when the CRP model had been implemented for a few weeks, I observed that although the students were making an effort to work with the CRP model during they were struggling in conducting their reflection[13]; from choosing what topic to reflect on and how to reflect on the topic..

They indicated that the CRP model assisted them in developing their clinical practice knowledge. They shared their experiences of the reflection process and highlighted the importance of the support and input of other people to assist them with their reflections about their practice. By identifying the different learning experiences they could gain from reflective practice, the students tried to make sense of the process of learning in reflective practice. Three aspects were identified that helped them make sense of reflective practice namely reflection process; need a friend; and reflection topics. Those three subthemes as seen in Figure 16, are now explored in more detail.

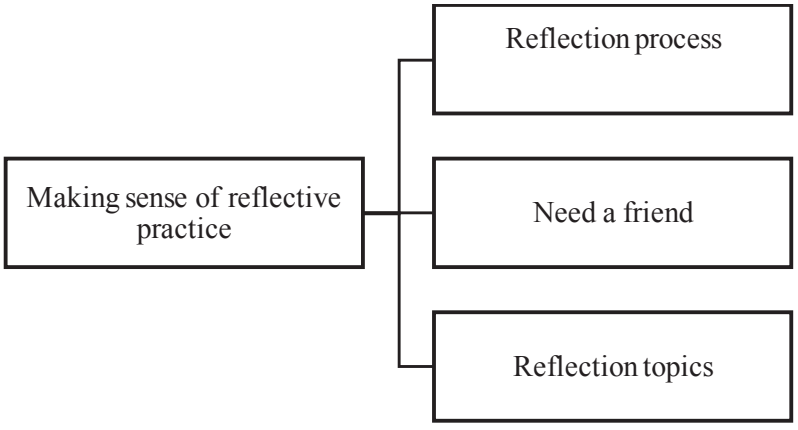

Figure 16. Theme 1: Making sense of reflective practice and its sub-themes

[13] Field notes during Tiara's supervision (30/09/13)

5.3.1.1 *Reflection process*

In the CRP model, students were expected to write a weekly reflective report related to their clinical experience. Reflective report writing was a new experience for the students. As a result, the students described how they found this report writing a unique process and how they wrote it differently.

> *So when I found a unique or new thing, I was confused in the beginning. Yet, since we had to write a reflective report, we were asked to describe the situation. Then we had to look for related literature. Then we analysed what had we done and how. Then we created a plan.* (Ruby-SN)

Ruby has articulated the reflection process she had completed during her clinical placement period. The steps of writing a reflective report that Ruby used were: describing; literature searching; analysing; and planning. The structure of the writing was consistent with the structured reflection template provided in the preparation session before the clinical placement started. Another student described a slightly different process.

> *When we found an interesting phenomena, then we evaluate, and looked for references directly. Therefore our knowledge were increased.* (Louise-SN)

Louise completed her reflection process by finding the phenomena – evaluating it and doing a literature search. In comparison with Ruby, Louise had a simpler set of steps and used them in a different order. Ruby did the literature searching prior to analysing her experiences, while Louise did the literature searching at the end of the reflection process. This process was highlighted by another student who also conducted a literature search at the end of the reflection process. Chloe indicates that her literature searching was conducted in order to find appropriate answers for the questions in the reflection process.

> *...from the patient's response* [following an action]. *What was the response from the patient? Why the nurses respond in that way? What was found in the*

literature? So I looked for updated information from the literature regarding that action. (Chloe-SN)

Another difference found with Ruby's approach to reflection was that she *created a plan*, this step was expected as part of the reflective process, however it was not evident in the discussions with Louise or Chloe. A plan is the step when you can plan actions to improve your performance based on the exploration of your previous experiences.

Here another student provided an example of how she reflected on one experience during her clinical practice where she was unhappy with the information provided by the doctor:

For example about the usage of epinephrin post extubation. I discussed it with the doctor, but I wasn't satisfied with the answer, therefore I tried to find the answer, and there was an article that mentioned about that topic. (Geraldine-SN)

Geraldine demonstrated that not only is she beginning to reflect on her nursing practice, she is becoming critical about the information provided by others (in this case the doctor) and is becoming self-directed in her learning to confirm or reject information. This is also an example of how Geraldine using the reflection process overcame the high power distance in the clinical practice setting, between herself as the student nurse and the doctor, who is usually regarded as having a higher more powerful position.

The process of reflection among students varied slightly. However, in general they started to reflect on something new, interesting or that differed from their previous knowledge or experience. Then, they would search the literature to find out what has been written about that topic and in so doing increased their knowledge.

5.3.1.2 ***Need a friend***

Some students mentioned that they needed someone to talk to about their reflections. This might be an example of one Indonesian cultural characteristic that is collectivist

(as described in Chapter One). In this study, students identified that they had a preference for having contact with another student or nurses during a shift to enable a discussion about what was occurring.

> *And there should be a partner during the shift whom I could discuss with.* (Ruby-SN)

> *I asked my friend or other nurses what should I do to deal with the situation... Sometimes I discussed with my friend, for example "Why I feel this way about the procedure?"* [My friend replied] *"I don't have the same feeling with you." Then I thought perhaps it's only me to have the feeling. This means that I don't have to pay attention to that feeling.* (Olivia-SN)

For Olivia, a discussion with her friend might determine her next action related to reflection. In her quote, Olivia described that she does not focus on her feelings as her friend does not have the same feeling. The collectivist dimension is strongly applied in this case. However, Olivia might have lost her opportunity to learn from her own experience (which was described by the emerged feeling) due to the fact that her friend did not legitimize the feeling, resulting in Olivia disregarding her feeling. This situation was one of the conditions where culture might influence reflective practice implementation in Eastern countries. Another student also shared her application of the collectivist dimension on her practice.

> *For me, discussion with a friend depends on the situation. For me, we do need a friend to emphasize* [what we have done]. *Even though, sometimes we feel that we do the right thing, but there is a need to get 'yes' from others.* (Melanie-SN)

Melanie reinforces what had been said by Olivia that a friend's comment is needed in order to identify whether other students have the same experiences or opinions with them. They are more likely to feel relief as they know that they are not alone in experiencing the situation, as in Donna's quote:

I need to talk to a friend...I felt more comfortable since I knew that other students experienced the same situation. (Donna-SN)

This reassurance about the situation she was encountering could be identified as a form of reflection and the need to further explore what had occurred. The application of collectivism is strongly identified during the implementation of the CRP model as some students provided examples of how comments from their friend could influence their reflection process.

5.3.1.3 ***Reflection topics***

The students' choice of reflection topics were varied. Some focused on clinical issues while others were more concerned with social and emotional issues:

Clinical procedures. (Elaine-SN)

The unique situation that we never had seen but it was found in the clinical setting. (Ruby-SN)

There were different situations from one ward to the other, and there were differences between paediatric patients and infants. So I feel there was something, interested to look for the differences. (Isabella-SN)

Not only clinical skills that need to be reflected. I think relationship with others too. (Ella-SN)

...feelings about something contradictive, dissatisfaction of something... (Irene-SN)

From the quotes above, the topics that students chose to reflect on included: technical procedures, feelings, relationships and differences occurring in the clinical practice. Technical or clinical procedures were the most common reflection topics chosen by the students in the CRP study during their first clinical placement. Nonetheless, a shift from a more traditional focus on procedure and skill development to more abstract matters such as feelings and relationships was

identified from the students' reflective report. From the quotes the students are illustrating an important shift to a more critical and holistic approach to their nursing practice. The students had commenced reflecting about their behaviour and feeling, they had started focusing on themselves and the impact they had on others during the clinical practice learning process.

The students had started to make sense of the reflection process, providing an important description that they were eager to create a better learning process and outcomes. In the next section, students shared positive impacts they had gained after the implementation of the CRP model.

5.3.2 **Theme 2: Positive impacts**

Almost all students had a positive experience using this new model because it 'pushed' them to think in a more structured way, resulting in feelings of being more knowledgeable. The students attained positive experiences which related to technical matters and emotional aspects of their practice. In their prior clinical practice, students were used to focusing on technical matters such as increasing knowledge about a clinical procedure, however in this CRP study, the students shared that focusing on emotional aspects became one of the positive impacts of the CRP model. This was due to the reflective activities that the students were required to complete during the implementation of the CRP model. There were four sub-themes (refers to Figure 17) which described the positive impacts from the application of the new model: finding the rationale; increased self-awareness; expressing feelings; and long lasting knowledge.

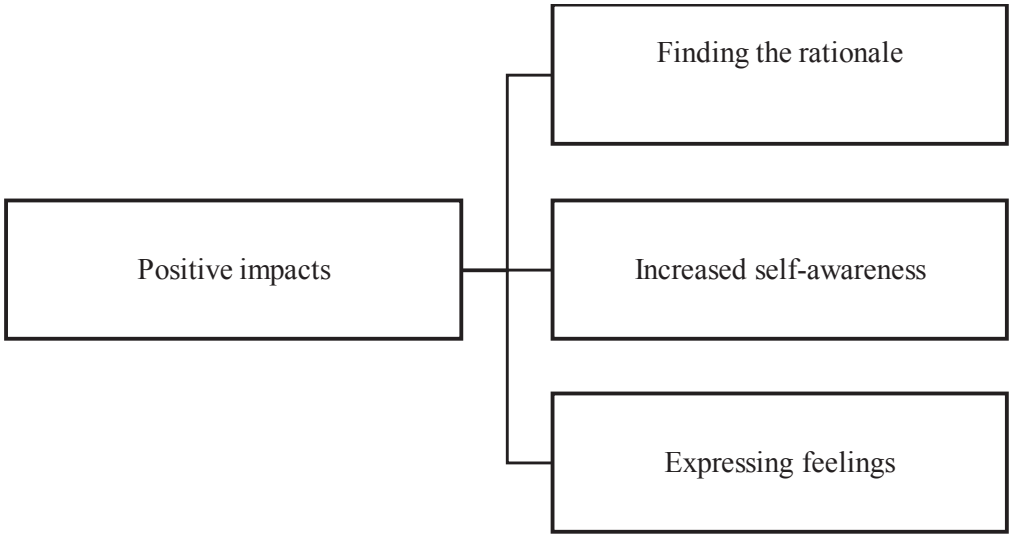

Figure 17. Theme 2: Positive impacts and its sub-themes

5.3.2.1 ***Finding the rationale***

The reflection process facilitated exploration of the students' clinical experiences and supported them to critically think about what had occurred during their clinical experiences. During the reflection process, the students were asked to link their experiences to the literature. As a result, students felt that they knew or understood more about what theory informed their actions.

> *...I am more open to why nurses or I did something. What is the basic knowledge? Then I found out that it should be done that way.* (Beth-SN)

Beth identifies the shift in her thinking. She poses a question to confirm her knowledge or experience. Nonetheless, Beth acknowledged that some of her actions during the clinical practice period were not based on the literature.

> [I realized] *so far, what I did, some were based on the literatures, some weren't. At the end, this evaluation can make a better future.* (Beth-SN)

Similarly, another student identified the benefit of the reflection process in terms of identifying if their nursing actions were based on the evidence within the literature.

> *Why should it be like that? So far, I have known that it should be like this. Finally, to find the answer I read some articles from the journal. After reading the journal, I knew that it should be like that.* (Geraldine-SN)

From the process of finding and reading appropriate literature, the students were starting to assess their performance and the experience according to theory and other evidence based literature. Here Jessica shares her reflection on a situation in the clinical practice setting.

> *When I was in my night shift, I had to do inhalation to a patient at 12 midnight. Unbelieveable. I told to the ward nurse "Couldn't we do this before the client sleep? Or, in the morning when the client wake up? Why should it be at midnight? We have to wake up the mother first, then the mother should wake up her child.". I can't imagine the situation... We know that in nursing we have Kolcaba's theory, Levine's theory, but we do not apply that theory. I found from the literature that the more technology is developed, it will not reduce the injury rate in children. Perhaps we can bargain with the doctor about the time of inhalation. A day after that, a senior doctor visited the client. The senior doctor got angry to the doctor who gave instruction about the inhalation time. Then, I thought maybe we can communicate it earlier.* (Jessica-SN)

Jessica shared her reflection about the inconsistencies of the theory and practice in the clinical practice setting. She was struggling to understand and questioned the reason why an inhalation must be done in the middle of the night when most of the patients are sleeping. At the end of her reflection, Jessica concludes that communication with the doctor should have been attended to much earlier to prevent this situation occurring. She is able to confirm that her findings from the literature were correct. Crucially, this may help her to challenge clinical and other hospital practices and discuss with medical and nursing staff treatment orders that may not be in the best interest of the patient.

5.3.2.2 *Increased self-awareness*

Developing a reflective practice approach has had an impact on the students' thinking processes. Students worked to improve their ability to appraise their previous actions or experiences. Students then realised that reflection helped them to better understand themselves and their capacities as nurses.

> *To be aware of ourselves. Today, I only can do this,* [tomorrow] *I should prepare more. Sometimes when we are not ready to take care of the patient, it would affect what we are going to do during that day.* (Jackie-SN)

> *Somehow, without evaluation, I won't be able to measure my own capacity even after two or three weeks of clinical practice. Reflective practice evaluated not only competencies and skills, but also moral or personal responsibilities.* (Olivia-SN)

Jackie expressed that reflection assisted in increasing her self-awareness of her readiness and ability to participate in the clinical practice period. While, Olivia highlighted that reflection increased her awareness not only to attend to technical skills, but also non-technical skills including her own moral and social awareness. Additionally, in the following quote Emily clearly states the value gained from her use of reflection.

> *I thought about what I had done. For example, the medication administration. I agreed that writing reflective report helped to evaluate our activities, such as whether I was doing the right procedures or interact with the patients. It stimulated me to understand what I had done.* (Emily-SN)

The use of the reflective report provided her with the structure to evaluate her nursing practice and the learning skills and knowledge she had gained. Another student reflected on an uncomfortable situation in the clinical setting. The reflection process assisted her to appropriately deal with this uncomfortable situation.

> *...without* [clinical] *orientation, I had been allocated* [certain] *patients. I had to write the* [patient] *report, did the procedures. I was panic at that time.*

> [Then I thought] *I had to reflect on myself, what did occur to me. That's one reason why I like to write reflective report in different situations.* (Isabella-SN)

During the clinical placement, the clinical educator or the head nurse in the ward usually orientates the students to the ward environment and the task they should do during the clinical placement period. However, Isabella experienced a different situation which she had to complete many activities without any prior guidance or orientation. The situation challenged her capacity as a student nurse in the ward. Using the reflective processes she acknowledged that reflection-in-action assisted her through an uncomfortable and unsupported situation and enabled her to think about how she had managed the situation.

5.3.2.3 ***Expressing feelings***

The students identified that a benefit gained from this new model was enabling them to express the feelings they experienced during clinical practice.

> *I can express my feelings at that time, whether it was happy or other feelings that might be different with other students who experienced* [a] *similar situation.* (Irene-SN)

> *...with this reflective report, I could be more sensitive to my own feelings.* (Jackie-SN)

> *...but the hindrance as well as something that help us to move forward if the feeling problem was solved.* (Olivia-SN)

Interestingly, Olivia described expressing feelings had a contradictory condition as *hindrance as well as something that help us*. It can be implied that reflection assisted Olivia in identifying and then dealing with her feelings during the clinical placement period, which enabled her to move forward. It is therefore not enough to use reflection to identify the feeling, the feeling then needs to be addressed, if not then reflection is seen as a hindrance. Despite the benefits of expressing their feelings, the students found that it was a challenge to write about these feelings.

> *...the hardest part* [in writing reflection] *was the feelings, particularly. We couldn't avoid the feelings since every time we interact with the client or the parents, or other nurses or other health professionals.* (Emily-SN)

In her quote, Emily emphasized that writing about feelings was not easy, however since as a student nurse she had to interact with many people with different personalities or characteristics then avoiding writing about feelings was impossible. Sophie added the reasons why writing feelings was hard for her:

> ...[regarding writing about feelings] *it was hard to write the future plan, it was too easy, it was not important...* (Sophie-SN)

Sophie mentioned that in writing reflective reports about her feelings she experienced difficulties in deciding the future plan related to the feelings. She was also afraid that writing about feelings would be regarded as a *not important activity* by the clinical educator as it was an unusual practice in an Indonesian education setting to explicitly express your feelings to the teacher. Nevertheless, the students in the CRP study balanced the benefit of expressing their feelings with the challenge they faced in writing about these feelings.

A significant difference in practice was experienced by the student following the implementation of the CRP model. The reflective report acted as a means for them to express their feelings. The structured reflection template required the students to be aware and actively search and find the underlying literature for their actions. It can be argued that the knowledge produced from this activity will be sustained for longer periods by the students.

5.3.3 **Theme 3: Struggling with the writing process**

Apart from the benefits the students gained from participating in a reflective practice process, they revealed some challenging issues that occurred during the clinical placement period. Writing a reflective report was the main challenge they faced. The report was one of two assignments required to be submitted by them and this report

required them to focus on the writing process. They shared how they struggled with the writing process despite the structure template provided.

Three conditions that contributed to the difficulty faced by the students in writing their reflective report were: being confused (on what to reflect on); they did not like the writing activities; and their physical tiredness due to the workload in the clinical practice setting (see Figure 18).

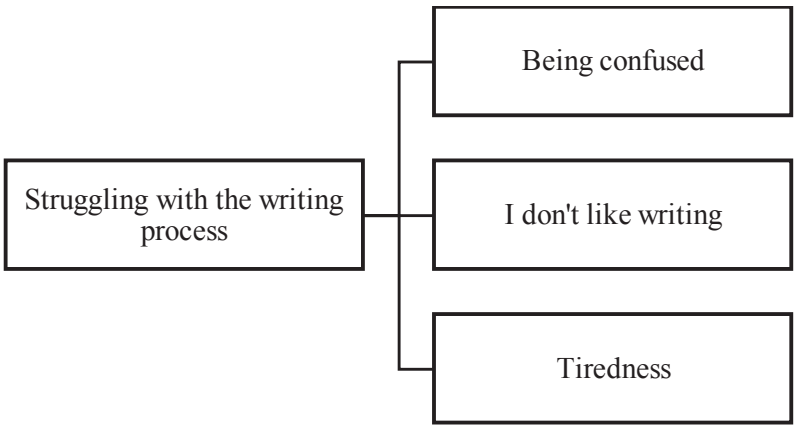

Figure 18. Theme 3: Struggling with the writing process and its sub-themes

5.3.3.1 ***Being confused***

Being confused was the most challenging factor faced by the students during the implementation of the CRP model. The student said that they were confused about what to reflect on.

> *Some times, until a week passed, I was still confused what to look for.* (Chloe-SN)
>
> *...until one week, I didn't know what to reflect on.* (Carol-SN)
>
> *...but if the implementation* [the reflective report] *is expected every week, then I will be more confused, what I can choose as the topic.* (Jessica-SN)

A common thread is confusion about the topic they need to write about in their reflection; and they highlight the issue of time. This is not an unexpected beginning

outcome when students are learning a new complex skill such as the ability to reflect on their clinical practice.

5.3.3.2 *I don't like writing*

The difference between the conventional practice model and the CRP model was the requirement for the students to submit the reflective reports fortnightly. This required the students to learn to write in a reflective manner. Not all students had these writing skills and some did not like writing. This raised significant difficulties for some students.

> *I am not a person who can write easily. I had to jot some points first.* (Chloe-SN)

> *In fact, I don't like writing. Sometimes what I write had different meanings to what I explained verbally.* (Carol-SN)

The result for some students experiencing difficulty with writing was an inability to adequately describe their experiences during the week. There was a recognition by Carol that she was not always able to capture the meaning of her experience and her attempts ended in conflicting stories from the one she was able to verbally express and her attempts at documenting the experience in writing.

> *Maybe I was too lazy to write, so what I wrote not as many as what I thought, or what I wanted to say. As a result, we didn't write a reflective report which described what we had reflected on.* (Beth-SN)

Beth noticed that what was in her thoughts was not so easily translated into a written format and she therefore ended up with a report that only partially described her reflective thoughts. This was a concern for her as she was then expected to submit the reflective report in order to demonstrate her reflection process to the clinical educators.

Another student, Jackie, expressed her preference for using the clinical educators' supervision time as the time to share her reflection.

I don't really like writing. I prefer the clinical educator come to the hospital and ask what I have been doing during the day. (Jackie-SN)

An interest and willingness to commit to writing is the fundamental factor in constructing a written reflective report. When a student is not interested in writing then they are more likely to write the reflective report just to fulfill their 'duty' as a student and the requirement to participate in designated activities. In this case, the objective of reflection, which is to learn from your own experience, is less likely to be achieved.

5.3.3.3 ***Tiredness***

The last aspect that challenged students during the implementation of the clinical reflective practice model was tiredness. Physical tiredness influenced students' willingness and ability to commit to writing a reflective report.

...but, one factor was tiredness. Our minds will get influenced by it and tiredness also influenced what we were going to write. (Geraldine-SN)

Geraldine described that tiredness she experienced influenced her capacity to think. Almost all students experienced tiredness during the clinical placement period it is a very common situation for students and might have influenced their progress and motivation during the clinical practice period. Quotes from other students supported what Geraldine had stated:

Physical condition influenced our mood to write. (Beth-SN)

To find an article was not easy and it took time. I couldn't find the right article if I'm tired. So, when I feel tired, it was difficult to write the reflective report, particularly when I am bored. (Ruby-SN)

The above quotes emphasize that tiredness or their *physical condition* is not only a significant negative barrier that influences the ability to write, but also the motivation to write. Indeed, if the students were not motivated to write or they got *bored* with their routine activities, then they would find it *difficult to write the*

reflective report. In other words, having motivation is important in writing the reflective report.

In summary, the challenges students experienced during the implementation of the CRP model were associated with the writing process. The challenges related to confusion over what to write in the reflective report, that they did not like to write or they were experiencing tiredness which influenced their writing ability.

5.3.4 Theme 4: Uncertainty in supervision process

Clinical educators employed two different strategies during their interaction with the students: to evaluate or to facilitate. To evaluate required clinical educators to identify or ask the students about their level of knowledge. While, to facilitate refers to a strategy of assisting the students learn by asking questions that will facilitate the students to think critically.

Student nurses in this study were able to differentiate when the clinical educators were facilitating the student to reflect on their experiences or when they were focused on evaluating student performance or achievement. The difference in the two approaches created feelings of discomfort among the students as they preferred the facilitation process rather than the evaluation of their performance. Adding to these differences, the students identified that the supervision sessions with the clinical educators were not regularly conducted and this led to uncertainty about the supervision process. Two sub-themes formed under this theme: evaluation versus facilitation; and time constraint, as can be seen in Figure 19.

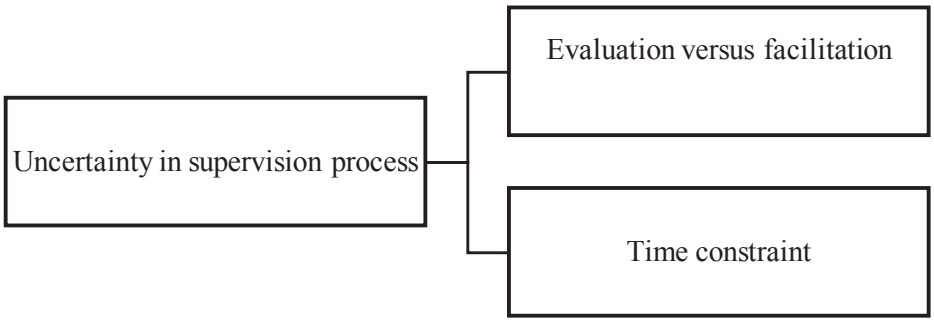

Figure 19. Theme 4: Uncertainty in supervision process and its sub-themes

5.3.4.1 ***Evaluation versus facilitation***

Students identified two different supervision strategies that had been used by the clinical educators: to either evaluate or to facilitate. To evaluate meant that the clinical educator came to the clinical setting, had a discussion with students, and asked many questions to identify whether the students had achieved the practice target or increased their knowledge and skills as an outcome of working in the clinical setting. The emphasis on evaluation is illustrated in these comments by students:

> *But there were non reflective clinical educators...* [they asked] *how's the patient's progress? What should we know* [regarding the patient case]. *Indeed, the clinical educator gave us homework since we couldn't answer the question.* (Ruby-SN)

> *In general, they conducted an evaluation, except when Ms. Tiara gave us examples from her own experiences. So we could learn from her experiences, and we could do it as well to our patient. Ms. Ayu focused on the evaluation of our knowledge.* (Jackie-SN)

The students had clinical practice experiences prior to the implementation of the CRP model. In the conventional practice model, the aim of the supervision process was to identify the students' progress by asking questions related to the patient case and the learning outcomes stated in the syllabus. In contrast, in the CRP model, the

clinical educator was expected to facilitate a student's learning process using the student's experiences.

> *This time, I feel that they* [the clinical educators] *are more.. they're coming to guide us, find the solution, no judgement* [on my performance]*, and more respect to my feeling. Previously, when they came, they asked "Please tell me about your patient" but now "What do you feel regarding practice in this ward so far?" or " What is the most interesting experience do you have?." In that way, I felt they really would like to know, not to evaluate.* (Olivia-SN)

> *I had experience with the reflective clinical educator when I was in the non-infection ward. The clinical educator came to the ward and used reflective questions such as what we have learned, how my progress is and at the end she emphasized our experiences.* (Ruby-SN)

Olivia discussed the feeling she had when the clinical educator asked different question during their visits to the clinical setting. This difference in supervision style created a more positive feeling for Olivia towards the clinical educators and how they supervise students. Meanwhile, Ruby shared her experience with a clinical educator who she identified as using a reflective model because of the type of questions being asked and how this in turn related to Ruby's learning.

Another student described the difference between reflective and non-reflective clinical educators:

> *So with the reflective clinical educators, we were facilitated* [to think of] *what we had done, but with the non-reflective clinical educators, we felt like we were required to achieve something.* (Ruby-SN)

Differences found amongst the clinical educators sometimes made students feel anxious because of the uncertainty of the supervision process, and concern about which approach would be used. This is a description of the strong uncertainty avoidance application. The students expected a clear and detail learning process that could be achieved through the supervision process. For some students, the clinical

educators did not fulfil their expectation about how the clinical educators would conduct the supervision process. This uncertainty about the supervision process was compounded by time constraint becoming another issue of concern for the students.

5.3.4.2 ***Time constraint***

Irregular supervision sessions caused the student nurses to have feelings of uncertainty. For the most part they did not know when the clinical educator would come to the clinical setting. Their only option was to wait for the clinical educator to come and hope that it would fit with their shift schedule. This resulted in a negative impact for some students.

> *...I have rarely met the clinical educator because when she came maybe I was on the afternoon shift.* (Beth-SN)

Indeed, other students mentioned that they either did not have an opportunity to meet with the clinical educator or had limited contact with them during her clinical period in a surgical ward:

> *For six weeks, I have not met* [the clinical educator]*, perhaps when she came, I was not on duty shift.* (Chloe-SN)

> *We were there for six weeks. I only met once with the clinical educator.* (Heather-SN)

For students who had the opportunity to meet with their clinical educator, the problem was related to the high number of students being individually supervised at the same time. Jessica gave two examples of the situation in the clinical practice setting.

> *Indeed, the allocated time provided did not match with the student numbers. Ms. Tiara had spent so much time to supervise six students.* (Jessica-SN)

> *Sometimes, what we need* [to learn] *was not being discussed because of too many students to be supervised. Once, there was ten students being supervised at the same time by Ms. Tiara.* (Jessica-SN)

Lack of time to discuss individual's learning need was due to the high number of students being supervised by one clinical educator at any one time. Consequently, the clinical educator was not able to provide individualised support for all students. This lack of clinical educator support posed a real disadvantage for some students as they felt they were not mentored to develop their reflective capacity.

In short, the students in the CRP study experienced feelings of insecurity as the application of the strong uncertainty avoidance of the Eastern cultural dimension, due to the uncertainty of the supervision process. This uncertainty was related to the method or strategy used during the supervision process and time constraints resulting in the clinical educators not coming to visit the students in the clinical practice setting as scheduled. As an outcome, the students proposed that the supervision process needed to be improved.

5.3.5 **Theme 5: Supervision needs to be improved**

A clear message from the students was the need to improve the provision of supervision by the clinical educators. This improvement was needed to reduce the students' feelings of uncertainty during their clinical placement period and suggestions included: group sharing and increasing supervision frequency. These suggestion are the sub-themes for this theme of supervision needs to be improved (Figure 20).

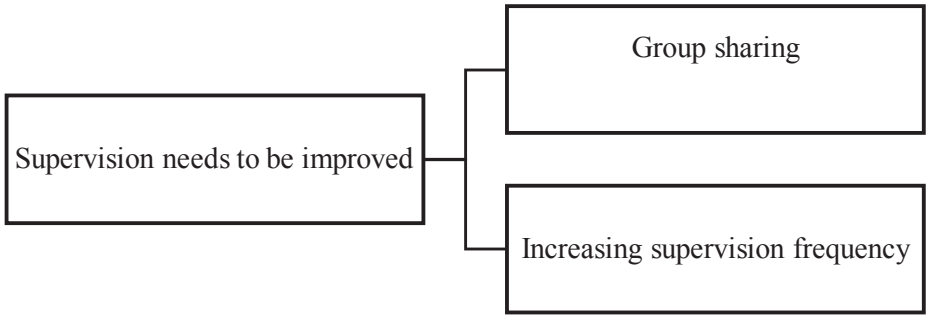

Figure 20. Theme 5: Supervision needs to be improved and its sub-themes

5.3.5.1 ***Group sharing***

When the students discussed their expectations for improvements in the CRP model, they demonstrated their collectivism behaviour as they voiced their preference to use a group activity to manage and ensure access to the supervision process. The majority of students asked for a group discussion session in order to learn more from other students.

> *If it is in a group, we can discuss, we can share what we had done, moreover what others think about that. As a result, we can get more than the individual* [discussion]. (Ruby-SN)

> *...when we* [have a discussion] *together, we are able to know, for example we don't know about procedure X but another friend had done and know it. So we are more open.* (Ella-SN)

Both Ruby and Ella identified the importance of sharing their experiences and reflections as a group. A benefit students anticipated from the group discussions was the assistance from other students answering questions, exploring other students' experiences or thinking through issues raised.

> *...perhaps when a clinical educator ask me a question and I can't answer that, my friend can help in answering the question. This means that the discussion can still going on.* (Irene-SN)

Irene suggested that a group discussion would make the learning process more open, drawing on other students' experiences and knowledge and therefore increasing everyones' learning. Building on these benefits, students mentioned that they would like the group learning to be in the form of bed-side teaching or a nursing round.

> *We can focus on one patient, from head to toe, learn together...bed side teaching for learning the procedures or general nursing knowledge, or knowledge transferred from the clinical educator...* (Irene-SN)

> *Similar to my friend, I really expect a nursing round, then we will have a discussion...in the discussion, we also learn. Perhaps my patients are different with my friend's patient, so we can share.* (Chloe-SN)

Both Irene and Chloe asserted that more indepth learning would occur if the focus of the sessions was restricted and enable increased learning to occur through knowledge transfer from clinical educator or other students' experiences that may differ.

5.3.5.2 ***Increasing supervision frequency***

Besides the method used for reflective discussions, the students also expected that clinical educators were able to increase their visiting schedule to the clinical setting. The students identified the need for a scheduled supervision time table from the clinical educators.

> *Maybe it is good for the future if* [the supervision] *is planned.* (Beth-SN)

> *Maybe once a week, but it should be a scheduled time.* (Ruby-SN)

> *At least once a week.* (Olivia-SN)

A scheduled timetable would assist the students to prepare for the supervision session. This is also an issue of equity for the students, especially if some students received increased access while others had minimal or no access to the clinical educators.

The recommendations from the students for the next implementation of the CRP model would be combined and discussed with the recommendation from the clinical educators. The application of these recommendations was expected to improve the students' learning experience during their clinical placement period after the CRP model has been implemented. For that reason, both the clinical educators and the students would struggle less and gain more positive experiences during the CRP study.

5.4 Summary

Findings from the first AR cycle highlighted the differences in experiences of the clinical educators and student nurses. From the clinical educators' perspectives, they were struggling during the implementation of the CRP model, particularly to be consistent with the conduct of the supervision process as in their schedule. The clinical educators acknowledged that students' abilities to manage self-directed learning and self evaluation were increasing. The student nurses indicated that they obtained more positive benefits from the CRP model, even though during the implementation period, they faced some challenges such as confusion with the reflection process, tiredness and lack of supervision process.

At the end the reflection session for both clinical educators and student nurses, they provided some recommendation for the next implementation period of the CRP model. The recommendations from the clinical educators and the students were matched; they proposed that group activity would be better employed in the second clinical placement period. Other issues from the reflection session that informed the next cycle of the CRP study were that: students would benefit from an increase in practice to enhance their ability to write the reflective report; and the students required more supervision time to be provided in the clinical practice setting. Using these findings the CRP model was revised. Detail information about the revised CRP model can be found in Chapter Four. The next chapter will present findings from the second AR cycle, including themes and sub-themes that emerged from the data.

Temuan dari siklus pertama RA ini menunjukkan bahwa pengalaman pembimbing klinik dan mahasiswa keperawatan tidak sama. Dari sudut pandang pembimbing klinik, mereka menemui tantangan selama implementasi model PiKiR, terutama dalam hal konsistensi melakukan proses supervisi yang terjadwal. Namun, pembimbing klinik mengakui bahwa pembelajaran mahasiswa dan kemampuan evaluasi diri mahasiswa meningkat. Berkaitan dengan hal tersebut, mahasiswa mengakui bahwa mereka mendapatkan manfaat positif yang lebih banyak dari model PiKiR walaupun selama masa implementasi, mereka menghadapi tantangan seperti rasa bingung terhadap proses refleksi, kelelahan, dan supervisi yang kurang.

Di akhir sesi refleksi, pembimbing klinik dan mahasiswa menyampaikan rekomendasi terhadap implementasi model PiKiR ini selanjutnya. Rekomendasi yang disampaikan bernada sama, yaitu aktifitas dalam grup yang dianggap lebih baik untuk diterapkan pada masa praktik klinik di semester dua. Isu lain yang terkait implementasi model PiKiR ini adalah mahasiswa membutuhkan latihan untuk menulis laporan reflektif dan waktu yang lebih lama untuk disupervisi di lahan praktik. Hal ini yang mendasari revisi model PiKiR; informasi detil tentang hal ini dapat ditemukan pada Bab Empat.

Bab selanjutnya akan membahas temuan pada siklus kedua RA, termasuk di dalamnya pembahasan tentang tema dan sub-tema yang muncul dari sesi refleksi.

6 Findings from Second AR Cycle

6.1 Introduction

The second AR cycle commenced when the CRP model was revised based on previous feedback and reflections obtained from the clinical educators and student nurses, as well as the observations undertaken in AR cycle one (for additional details about the second AR cycle see Chapter Four). This chapter provides findings from the second AR cycle. The data used in this chapter were collected from in-depth semi-structured interviews with the clinical educators and five critical discussions held in the student nurses final week of clinical placement. Additional data from a follow-up session were collected from the students six weeks after the clinical placement was completed. The timing of the evaluation session enabled the students to have adequate time to reflect and to provide some distance from the clinical placement setting. These three sets of data (clinical educators' data, student nurses' data, and student nurses' post placement data) were analysed separately using thematic analysis. For further details on the data analysis process see Chapter Three.

Themes and their related sub-themes that emerged from the data are outlined in this chapter and include three themes from the in-depth interview with clinical educators; four themes from the critical discussions with student nurses and five themes from the post placement session held with students. This chapter is concluded by a brief summary of findings from the second AR cycle.

6.2 Clinical Educators

During the reflection session (semi-structured interviews), the clinical educators shared their thoughts, feelings, and experiences regarding the implementation of the CRP model after the second cycle was completed. They focused on the changes in

the students' learning during their clinical placement period and its impact on their practice as clinical educators and on the students' development. Three themes were identified within the data as can be seen in Figure 21.

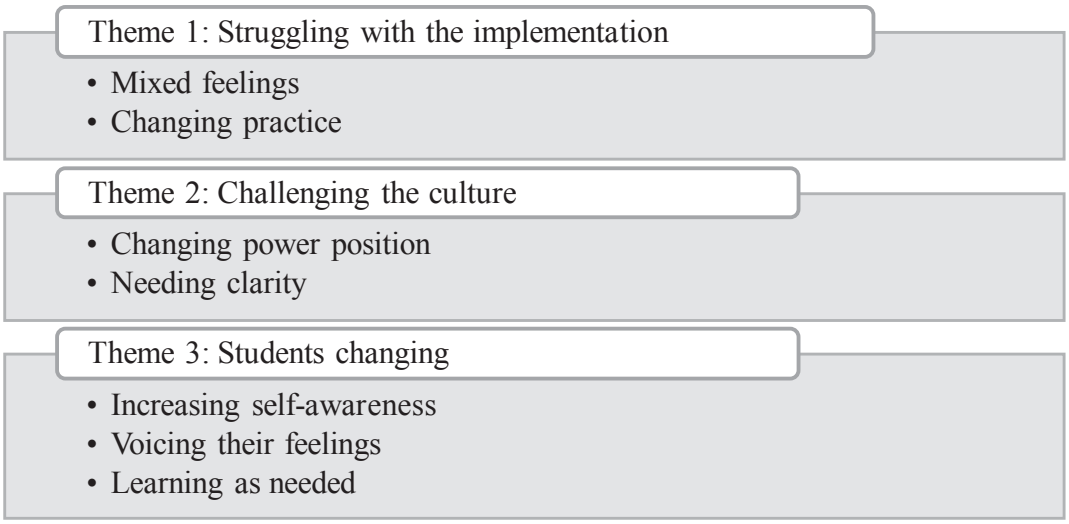

Figure 21. Clinical educators' themes and sub-themes in the second AR

6.2.1 **Theme 1: Struggling with the implementation**

In the first AR cycle, although the educators acknowledged the benefits of the model for students' learning they demonstrated some hesitancy in changing their behaviours to support the model. During the second AR cycle, they continued to struggle with the implementation of the model despite the changes they had suggested being implemented. This might have been an indication that the acceptance of the CRP model still required further support to become embedded as acceptable approach for clinical and educational practice. Their struggle was manifested through two aspects, mixed feelings and changing practice (see Figure 22).

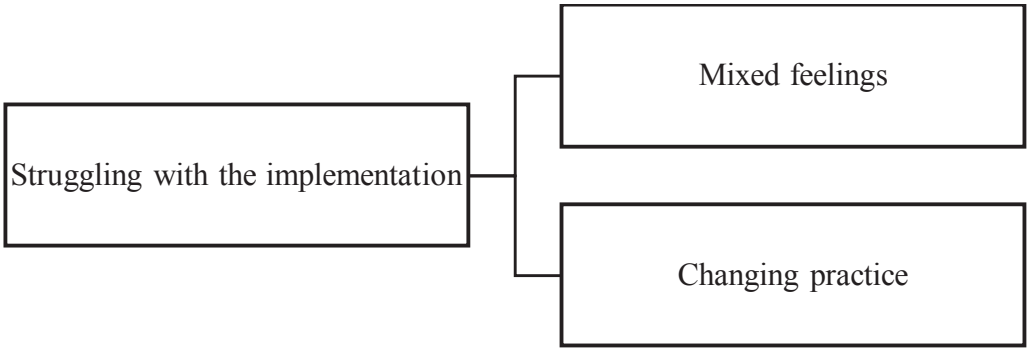

Figure 22. Theme 1: Struggling with the implementation and its sub-themes

6.2.1.1 ***Mixed feelings***

Clinical educators grappled with a range of feelings during the clinical practice period. They described their feelings towards the CRP model and its effect on their own practice as well as on the students' development. Interestingly, the feelings experienced by the clinical educators were varied.

Two clinical educators described their positive feeling towards the students' development after the CRP model was implemented. Sekar and Ayu shared that they were amazed with the effect of the model on the students, as they had identified changes to students' critical thinking ability as described below.

> *Grace* [one of the student] *is different. I frequently told her that she changed significantly, from the beginning* [of this study period]*...Each time during supervision, I asked other students to look up her work, that's what I want. I was amazed.* (Sekar-CE)

> *The most obvious change was Sophie. I could identify the difference within Sophie in semester one and semester two. It was significant.* (Ayu-CE)

In her quote, Sekar expressed her acknowledgement of the change in front of the student and her peers. By doing this, Sekar gives direct positive reinforcement to the student, which may encourage the student to maintain what she has done so far. Ayu's quote was about her identification of a student's progress across the two semesters, as she referred to the *significant* changes within Sophie.

Not all experiences were positive, here Putri talked about her conflicted feelings as she mentioned a challenging situation related to the student ability in expressing something.

> *During the supervision period, the challenge was the students who were not able to express what had happened to them. But for me, something challenging is interesting.* (Putri-CE)

Putri highlighted the students' inability in sharing their experiences as a challenge for the clinical educator in the CRP model. Fortunately, Putri regarded this condition positively as an interesting challenge for her, rather than a failure of the model.

Two clinical educators pondered whether they themselves progressed as a clinical educator in the CRP model.

> *Hmm I think we should change with the students but maybe…because I don't have lots of experience so I feel like...I didn't.* (Tiara-CE)

> *Hmm I felt like I didn't change a lot, but my thinking process yes…so not only students who became better, we should become better as well.* (Sekar-CE)

Tiara was trying to express her uncertain feeling about her progress as a facilitator in the model. She associated this uncertainty to her limited experience as a clinical educator. Sekar acknowledged that she thinks differently, although she was unsure about other changes in herself. Both Tiara and Sekar had noticed that the students had changed. These feelings of uncertainty might be due to the effect of strong uncertainty avoidance as one of the cultural dimensions in Indonesia. Anxious feelings due to uncertainty avoidance may get stronger in a situation where the individual has to face a new situation, in this case these feelings refer to the implementation of the CRP model (Hofstede, Hofstede & Minkov 2010).

Whilst a number of educators reflected and shared their feelings about using the CRP model, another clinical educator critiqued the effect of the CRP model on the students.

> *So, I questioned how this model, although I agreed that the students could learn many things, but why they only chose a small topic? Too specific topic to be learnt. The students would choose at their will…The student should learn about the patient's case, not a free topic. So, when I conduct a supervision, I can focus on patient case.* (Gadis-CE)

In the CRP model, the clinical educators were expected to encourage and support the students as they shared their reflection during the supervision session. Gadis notes that there was a change in her discussion with the students due to the students choosing a specific topic to reflect on, not the patient case as Gadis expected. This left Gadis feeling that the CRP model diminished students' learning experiences as she referred to the focus as *too specific to be learnt*. Gadis continued providing two additional examples:

> [For example] *we knew that the patient experienced nutrition problem, but the reflection was about blood sample that was taken twice. The blood sample was in the fridge, they* [a student and a nurse in the ward] *didn't check it before. So, only a little thing as that. In contrast, we expected the student to understand more than that.* (Gadis-CE)

> *Another student chose the topic about feeding. She focused on the nutrition needs. It could be because her other assignment was about nutrition, so that's why she chose nutrition as the topic to reflect on.* (Gadis-CE)

From those quotes, Gadis was trying to rationalize her feelings of dissatisfaction about the CRP model that she considered lessen the learning process. Nevertheless, these mixed feelings as described by the clinical educators potentially impact on their ability to fully implement the CRP model into their practice. Some of the clinical educators experienced the CRP model as a positive addition to their practice with others troubled that it might reduce the students' learning process or their own capacity as clinical educators.

6.2.1.2 ***Changing practice***

The clinical educators' exposure to the CRP model appeared to enable and motivate them to change their practice and change the way in which they worked with students. Changes they were experiencing included the preparation they did prior to each supervision process.

> *Yes I also studied* [before the supervision process]. *When I planned to supervise the students, I already knew what the students wanted to discuss in the supervision period from our previous meeting. So I read more* [about that topic]*...I also linked it to my own experiences.* (Ayu-CE)

Ayu was trying to describe what she did before she conducted a supervision process and outlined how she was more attuned to the students' preferences and learning needs. She acknowledged that she prepared more when the CRP model was implemented than she had previously. Another clinical educator, Maharani, expands on the experience of changing her behaviour from an impatient to a more patient person.

> *From my side, I was challenged because I am an impatient person. I was trying…In the beginning, I tried to remember that we were applying a new model. As a result, I had to refrain myself not to ask too many questions. I was learning as well. I was not automatically changed, since it is a new model, right.* (Maharani-CE)

Maharani reflected on her behaviour illustrating that the CRP model made her more conscious of her own behaviour and highlighted the need for her to reflect on how she was implementing the model. Whilst she acknowledges that the model had facilitated a behaviour change in the way she worked with the student nurses, she is struggling to change her teaching approach and has to *refrain myself not to ask too many questions*. The change in Maharani's practice leads her to note that she is *learning as well*.

Another noticeable change that occurred for the clinical educators was related to the questioning technique used during the supervision process. Ayu acknowledges her lack of knowledge about questioning techniques during the supervision process. To increase her skills, Ayu used reflective questions provided in the Research News Update.

> *I tried to remember all questions. I always bring the copy* [of the reflective question examples] *with me during the supervision process...After I conducted the supervision, I looked at the copy. I would like to know whether I used the questions in the right way. In other words, I learned to ask.* (Ayu-CE)

The Research News Update here acted as a supportive reminder during supervision sessions and demonstrated Ayu's commitment to learning new skills as an educator. Ayu's quote demonstrates an active engagement with the implementation of the CRP model. She finishes her quote with a confirmation of her skills development that she *learned to ask*. Another clinical educator shared her reflection on the supervision process that also related to the questioning technique.

> *I analysed what was inappropriate, the questioning technique or the topic* [of discussion]. *Then, I think again, perhaps for that aspect I should ask this question.* (Putri-CE)

Putri described her thinking process when she looked back on a supervision process, this is using reflection-on-action. Putri's reflection implies that she acknowledges different questioning techniques might be applied in different situations.

Interestingly, Tiara acknowledged the change in her own learning and practice following the CRP model implementation.

> *Indeed, the clinical educators gained something from students' reflection. When the students found or experienced something, then they searched the literature, they shared it with us,* [as a result]*, we learned something.* (Tiara-CE)

A significant outcome of the introduction of the CRP model has been the seeking out and sharing of knowledge. This was a new experience for the clinical educators as they acknowledged the students' contribution to their learning as clinical educators. This shared learning occurred against a backdrop of generally positive as well as some negative experiences for the clinical educators, who at times, struggled with their changing role expectations.

6.2.2 **Theme 2: Challenging the culture**

Tiara's quote in the previous section indicates that she accepted a shared learning process with the students. She challenged the culture of high power distance where the source of knowledge is usually the teacher. The CRP model was developed by integrating Indonesian cultural characteristics within the model in order to provide an improved clinical practice experience for the student nurses. The clinical educators indicated that the new model challenged Indonesian cultural characteristics, particularly the culture within the education setting. One clinical educator mentioned that the CRP study *changed the culture which see the students as subordinate*. The challenges relate to both power distance and uncertainty avoidance concepts. These are explored through the sub-themes of: changing power positions; and needing clarity (Figure 23).

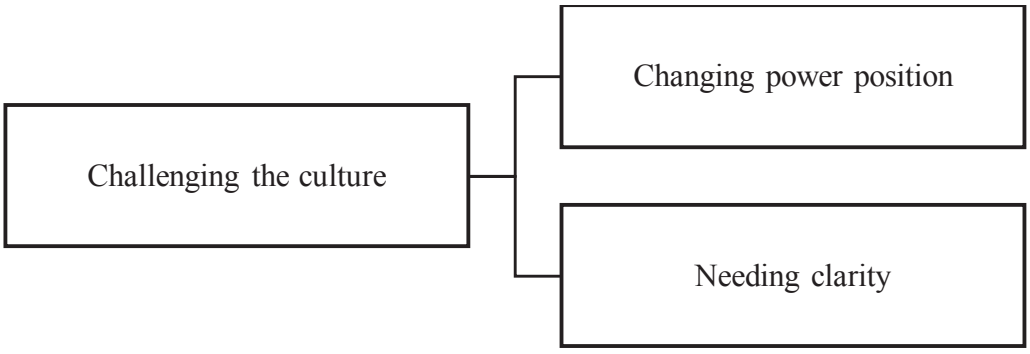

Figure 23. Theme 2: Challenging the culture and its sub-themes

6.2.2.1 ***Changing power position***

In general, students in high power distance countries would be positioned as the subordinate of the clinical educator. For instance, it is seen as a teacher's responsibility to determine what students should learn. However, during the clinical practice period, it was noted that for most clinical educators the CRP model influenced a change in positioning, especially their relationship with students during the clinical practice period. For some, this was a positive change:

> *...It changed our culture; we always on the top and see students as the subordinate.* (Maharani-CE)

> *For me, we are similar. They soon wil become our colleague.* (Putri-CE)

Maharani and Putri discussed the changing relationship between clinical educators and the students. They indicated that they now regarded their position as more equal, with students being less hesitant about speaking up during the supervision process.

> ...[a student said] *"but mam, it should be like this"* [and I responded] *Okay, but I'd like to see your reference...* (Ayu-CE)

Ayu gave an example of how the student challenged her explanation giving an alternative perspective she had found during her reading of the literature. Previously, the student would have accepted the clinical educator's explanation without questioning its accuracy; an illustration of the high power distance concept. However, after the CRP model was employed, the student was able to react to the clinical educator's explanation with alternative information. This is a clear indication of a rebalancing of power between the clinical educator and student nurses.

In contrast, another clinical educator wanted to maintain her power position by taking responsibility and ownership in directing the students' learning process:

> *But the reflective report was only about that matter. So the students were allowed to choose* [their own reflection]. *So, what I think now is for our*

students we direct their reflective activities. Oh this student should do this. (Gadis-CE)

Gadis asserted her belief about her role, she was struggling to acknowledge that the students could have a level of independence in what they were learning and did not fully adjust to the role as a facilitator, instead continuing to be the driver of the learning process. These different perspectives illustrate that the CRP model has not had universal acceptance by the clinical educators. There remains a need for on-going mentoring for some clinical educators if the model is to become fully integrated into the clinical education process.

6.2.2.2 *Needing clarity*

An Indonesian cultural characteristic that strongly influences the learning process is uncertainty avoidance. People living in a strong uncertainty avoidance country can feel insecure when they face a new situation. Accordingly, it is anticipated that both clinical educators and student nurses would experience feelings of insecurity when learning to use this new model. In order to overcome these feelings, the clinical educators indicated that a clear and detailed guideline was needed to support the assessment of written reflective reports.

I think not all students fully understand about how to reflect. They wrote whatever they want. There should be a guideline to do that. Then, in assessing the reflective report, we need clear indicators. (Putri-CE)

Moreover, Putri added by saying:

So, this model can describe students' reflective skills and the learning process occurring inside the students. That is the challenge part because we are used to indicators, like the quantitative approach. (Putri-CE)

Putri suggests that the reflection and learning occurring inside the students is an implicit process; therefore, it challenges the clinical educator to find alternate ways to assess reflective practice and learning. Putri emphasizes that clear indicators are needed to assess students' reflective ability, despite the assessment and weighting

form provided in the syllabus. These quotes imply that certainty is important not only for student nurses but also for them as educators. They needed clarity in relation to how assessment would be undertaken. Moreover, Tiara asked for clear indicators in assessing group reflective discussions.

> *One more thing, reflective group discussion also needs to be assessed* [with clear criteria]. (Tiara-CE)

Indeed, Tiara critiqued a student who did not write the report as the structured template provided.

> *One student did not follow the 5Ds* [the structured reflection template]*, but she thought that she did well doing the reflective report. I did not feel the same way though.* (Tiara-CE)

Tiara was referring to 5Ds, a structured reflection template, used in the second clinical placement. The structured template was developed based on the reflection session with clinical educators and student nurses (details about 5Ds can be found in Chapter Four). Tiara found that the students who used the 5Ds as a framework for their reflection were more likely to gain benefits from the reflection process.

> *For students who wrote* [reflective reports] *using 5Ds, it was clearer. Hmm, 'the diamond' they got was clearer. Previously, it was not really clear what was significant* [for the students]. (Tiara-CE)

Tiara believed that the students who used the structured reflection template were more likely to demonstrate what they had achieved from the learning process that she called *the diamond*. A metaphor of *the diamond* to describe the knowledge gained by the student is showing how Tiara valued the learning process. This is an illustration of a worthy effort (refers to using the structured template), may give you a worthy result (refers to the knowledge gained in the learning process).

In brief, data from clinical educators after the completion of second clinical placement period demonstrated that almost all clinical educators had to deal with cultural challenges during the implementation of the CRP model. The challenges,

particularly, were related to the high power distance dimension described in the first sub-theme (changing power position) and strong uncertainty avoidance dimension that related to the second sub-theme (needing clarity).

6.2.3 **Theme 3: Students changing**

In addition to the changes the clinical educators were experiencing in their role as described in the previous section, the student nurses were also changing. The clinical educators identified that the students were developing an increasing self-awareness, actively voicing their feelings and identifying the learning they required (see Figure 24 below).

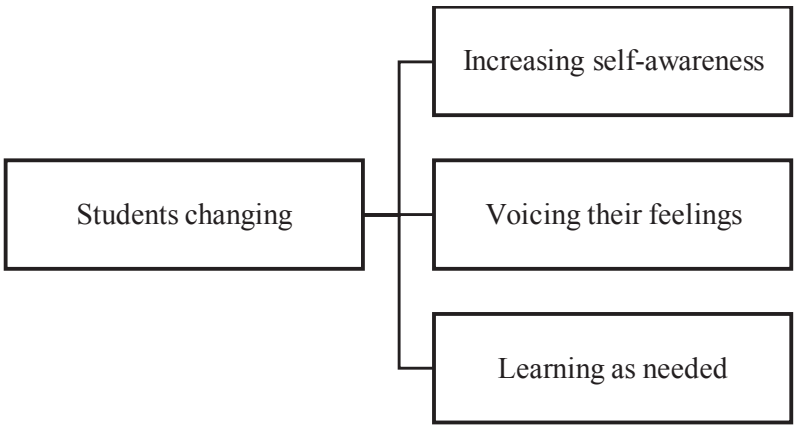

Figure 24. Theme 3: 'Students changing' and its sub-themes

6.2.3.1 ***Increasing self-awareness***

The majority of clinical educators participating in this study indicated that using reflective practices assisted students to be aware of their own learning process during the clinical placement period. This self-awareness occurred when a student was required to look at their own practice and behaviours and to analyse their past experiences. This increasing self-awareness assisted students in identifying their future actions. By participating in this reflective process the students increased their sensitivity to identify their current knowledge level and future learning needs. Students' self-awareness was growing as indicated by these quotes:

> *In general, from my experiences, the students are aware of themselves. They can evaluate themselves...For example,* [the student said] *"I was doing this way but I realized that I had to do it that way"...the students never think like this before.* (Maharani-CE)

Similarly, another clinical educator described students' self-awareness when she asked the student to reflect on her experience a week prior to the supervision.

> *A week after, I asked* [the student]*: "What have you got from your experiences last week?" Some students were able to answer it clearly: "I learned from the journal articles that I should do this, this, and this* [three points]. *However, at that time I only did this* [one point]*"* (Putri-CE)

From both quotes, the clinical educators portray the students' self-awareness as an ability to evaluate themselves and their learning according to their experiences. The students were able to compare what they did in the practice to what the literature said. This self-awareness was often illustrated within the writing of the reflective report, as described by Putri.

> *This means that by writing the reflection, she* [the student] *assessed her weakness carefully. So in the following week, she knew what to learn. This is good I think. If she didn't express what she thought, then it wouldn't be like that. So, this* [reflection] *was a stimulus for her, she was motivated to write.* (Putri-CE)

Putri acknowledged that reflection encouraged the students to think about their future actions and the students could determine their future learning based on their reflection.

6.2.3.2 ***Voicing their feelings***

Another obvious change noted by clinical educators was around the students' ability to express their feelings. The CRP model enabled students to voice their feelings about their clinical practice experiences.

> *One student told me a story about her experience in patient discharge. She was so emotional when telling me the story…At that time, I could see that she was happy and relieved after telling the story.* (Putri-CE)

Putri emphasized that using reflection in this way was beneficial for the educator as they were able to better understand what the students were experiencing during the clinical placement period. Putri highlighted the often emotional aspects of nursing practice and that a significant outcome of reflective practice is the student's ability to explore their feelings about what had occurred. The supervision process provides a supportive environment for this telling of the story to occur.

> *For me, by using this model, I know what students go through during their learning process. Previously, we never give an opportunity to the students to express their experiences during clinical placement period.* (Putri-CE)

She goes on to acknowledge the benefit she gained from using the CRP model since it enabled her to gain a fuller understanding of the student's learning experiences, and the clinical situations they have experienced therefore enabling support to be provided to extend the learning. Meanwhile, Sekar added that during the supervision period, they found that some students were not afraid to speak up or to respond to the clinical educator's statement influenced by their increasing awareness that voicing their feelings was important to their development.

> *Grace's* [one of the students] *changes were obvious. She was more knowledgeable and have a courage to say something…not only receive information from me.* (Sekar-CE)

> *They were more courageous, I think. This means that they were dare to bring about the topic in an active position.* (Sekar-CE)

Sekar appreciated one student who had the courage to provide a response to what she said in a discussion. Then a general comment was added about all students that seemed to have made similar progress as Grace, the student, in term of having courage *to bring about the topic in an active position*. Both quotes from Sekar

reinforced Putri's statement about the benefit of reflection as a means of voicing their feelings and actively exploring a topic. These quotes highlighted their appreciation of the students who now voiced their knowledge and opinions as part of the CRP model learning process.

6.2.3.3 ***Learning as needed***

Clinical educators indicated that students' learning was now being based on the learning deficits and interests that the student identified. The students were now taking responsibility for their own learning, they were less passive and were becoming self-directed learners, as outlined by these two educators:

> *One student who did good during the practice, she was able to learn a nursing instrument which she preferred to learn, according to her needs.* (Tiara-CE)

> *One day, the student actively told me "I found evidence about infant's position" or "I read an article about this and this." I told myself this is good. It is good for student if they can answer their own questions using information from articles in journals."* (Maharani-CE)

Maharani went on to share an example of how a student actively decided what she would learn based on her experience:

> *In the conventional model,* [we usually said] *"Find the articles and discuss it with me later." Now is different. The students knew their weakness, and therefore they promised to themselves* [to learn about it]*, and I only listened to what they wanted to learn.* (Maharani-CE)

The decision on what to learn was becoming the student's responsibility as an outcome of the CRP model. The students were also starting to decide how much they wanted to learn about the topic as Gadis states.

> *Students were free to decide how far they wanted to learn something.* (Gadis-CE)

Another clinical educator expanded this observation about the students being *free to decide* what and how to learn something through the group reflective discussion.

> *Yes, at that time, I did not ask who had discussed it in reflective discussion group, but the student I asked was able to answer my question. Then, she told me that she knew it because the topic had been discussed in the group.* (Ayu-CE)

In some cases the group discussion was led by one of the students without a clinical educator's presence. This illustrated that students were choosing the topic according to their own needs at that time. During the group discussion, students were reflecting on their practice, suggesting ideas and topics for shared learning and being active participants in the discussion as they questioned one another and learnt together.

In brief, the clinical educators revealed that they were still in an on-going process of adapting and integrating the CRP model into their role as clinical educators. Whilst most clinical educators were embracing the change, others were struggling with the process and the challenge of changing their own practice. Another possible reason for their struggles was the cultural challenges occurring during the clinical practice relating to the concept of high power distance and strong uncertainty avoidance. Nevertheless, the clinical educators noticed the positive change of behaviour in the students after the CRP model was implemented. Now the findings from the student perspective will be discussed.

6.3 Student Nurses

The student nurses' reflections (collected during critical discussion with them) on the implementation of the CRP model and the research process generated four themes: developing expertise; feeling competent in practice; creating a safe space; and courage to speak up. Details of each theme and its sub-theme can be seen in Figure 25. These will now be explored in more detail.

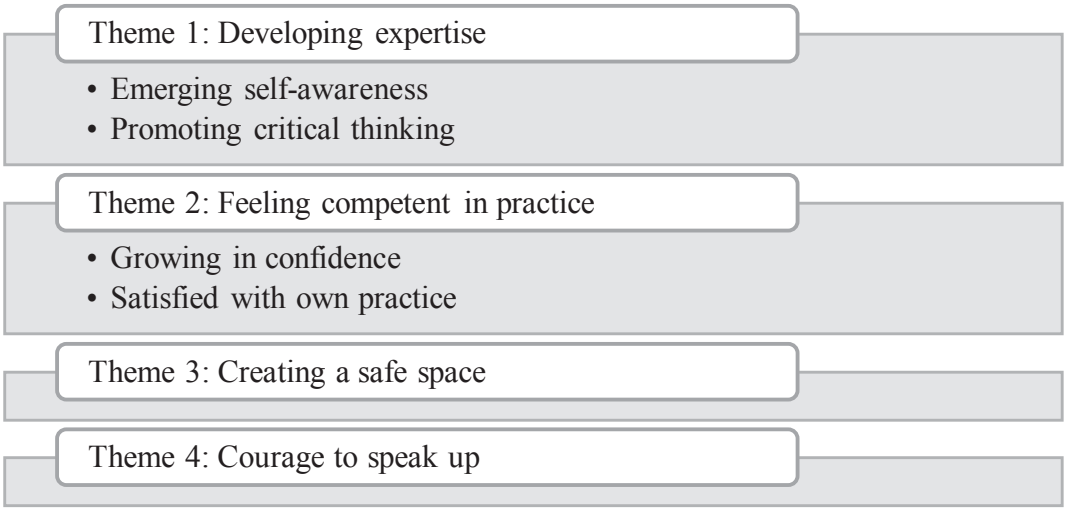

Figure 25. Student nurses' themes and sub-themes

6.3.1 Theme 1: Developing expertise

One of the nursing curriculum clinical practice aims was to provide students with an authentic clinical experience. The CRP model supported students to learn in order to develop their expertise as graduates of the Paediatric Nursing Specialist Program. To develop expertise, the students should be aware of their knowledge and skills level, as well as being able to consider the impact of the clinical environment on their practice. In the reflection sessions conducted after the clinical placement was completed, the students shared examples of their increased knowledge and skills. They were able to describe how their expertise developed after the implementation of the CRP model. Another characteristic the students were developing was their

ability to think critically in order to provide appropriate and safe care to their patients. Providing appropriate and safe care to the patients is crucial to ensuring safe nursing practice. These two aspects became the sub-themes under this theme: emerging self-awareness; and promoting critical thinking provide the foundation for developing expertise (Figure 26).

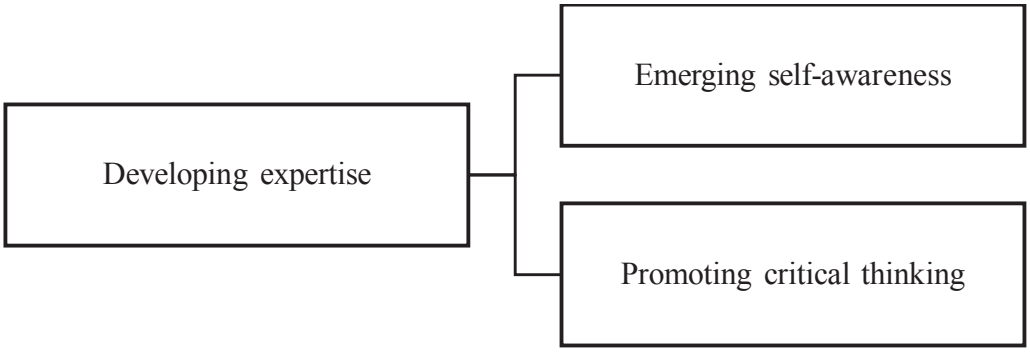

Figure 26. Theme 1: Developing expertise and its sub-themes

6.3.1.1 ***Emerging self-awareness***

The student nurses identified that reflection assisted them in increasing their self-awareness in terms of their: learning process, nursing care intervention and impact on their increasing knowledge development during the clinical placement period.

> *Previously, we did something because it was an assignment. But since I had to do it every week, we had to find something new to write. In another word, we updated ourselves. As a result, our knowledge was increased.* (Louise-SN)

Louise's quote highlighted her awareness of the learning process. She acknowledged that she was becoming more self-directed in her learning rather than just completing the allocated assignments. While, Emily shared her increasing self-awareness in relation to providing a safer clinical practice:

> *For example, in administering medication using injection,* [I] *focused more on many kinds of medication, administration strategies, drugs interaction, what aspects should I pay attention to. That's how I was aware of my action. Focusing on the rationale of the action.* (Emily-SN)

Emily in her quote provides a checklist of the things she must consider prior to administering a medication. This active engagement with a clinical task demonstrates the need for considerable clinical knowledge and critical thinking skills to contextualise the clinical task. Olivia, in the next quote, describes in detail changes in her behaviour and thinking about the use of reflective writing.

> *I personally become more honest to myself. Think deeper. In the first semester, I focused on whether my writing* [reflective report] *looked good or not, but in the second semester I focused more on what I can get from this writing. I must had something different from it, not only submitted it to the clinical educators…but, when my patient died, I reflected on myself, I became anxious whether she died because of my actions or bad prognosis…In the beginning, I did not want to reflect on it, but after I discussed it with my friend, she suggested me to face the situation.* (Olivia-SN)

Olivia was initially reluctant to reflect on her experience (uncertainty avoidance) however in sharing her concerns with her friend she was supported to overcome this and was then able to accept her own feelings through reflection, alleviating her anxiety caused by being in a conflicted situation. She was also aware that her learning process through the use of writing reflections had now changed, enabling her to fulfil her learning needs during the clinical practice period, not only do routine activities to complete the assignment.

Another student highlighted the benefit of reflective practice in her increasing self-awareness. She has related the development of the reflective report to assisting with the identification of the students' learning needs.

> *Because the reflective report matched our own need. We looked for what we needed to learn, we learned it by ourselves. So, we were able to identify what our needs were.* (Ruby-SN)

This quote emphasizes that reflection enables students to learn new knowledge and skills based on their own learning needs. To achieve this, students must be aware of their past and current experiences in order to identify what they need to learn for

their future clinical practice. Above all, this is a description of a student-driven learning process, where the students determine their own learning direction.

6.3.1.2 *Promoting critical thinking*

The capacity to reflect was acknowledged by the students as requiring the ability to think critically. This may have been due to the students' use of the structured reflection template, where they were asked to analyse past experiences using existing literature. This resulted in the students supporting their practice by engaging with theory and evidence. Beth highlights an increase in her reading:

> *By reading more articles as a part of reflective activities, I kept thinking whether what I did was right or wrong. I got more from reading the articles.* (Beth-SN)

Beth also attributed the reflective activities to increasing the value gained from reading articles. Other students provided examples about their experience and commitment to the use of evidence and the need to think critically which was facilitated by reflection activities during their clinical practice.

> *...if oro-motor stimulation is an independent nursing care, why the nurses did not do it? Later, if something new has been found, the nursing care will be based on the evidence. That's what I thought.* (Ruby-SN)

Ruby discovered from the literature that oro-motor stimulation can be undertaken by nurses working with newborns in order to stimulate their sucking reflex. She expected that nurses in the ward would deliver this intervention, demonstrating an application of evidence-based practice and was disappointed when this was not evident. Meanwhile, Sophie shared a story of when she had to separate twin babies into separate incubators and how her thinking around this stimulated her to read about this topic.

> *Then I knew that they* [two twin babies] *were both happy together. I read* [from the literature] *that there were three factors involved in it. ... So I analysed that this life need a balance between physiology and psychology*

> *aspects…from reflective report activity, I got benefit for myself someone who was so lazy to read something.* (Sophie-SN)

Sophie identified three reasons why twin babies should be kept together in one incubator. She felt relieved because she not only learned something from the literature that helped her understand why she was feeling uncomfortable about separating the twins, she had pushed herself to read when it was not what she would usually do '*someone who was so lazy to read something'*. The structure of the CRP motivated Sophie to not only search for relevant literature but to read this and relate it to her practice and how she was experiencing practice.

As an outcome of the reflective activities the students have proposed that past actions were not always based on evidence. The students now spent more time thinking about what they could do in the future. This thinking process occurred iteratively during the clinical practice period, which assisted students to be more aware of their practice rather than doing the routine rituals and activities without thinking about what they are doing.

> *So I was not only did the shift and the routine activities, but there was something that made us curious. Think for the future, than only do the routine shift activities.* (Ella-SN)

> [Then] *a question was emerged: why? From there, [I found] this this this emerged. What I can do in the future*. (Andrea-SN)

From both quotes above, the students affirm that their growing capacity to reflect on practice has assisted them to expand their thinking, their questioning, and their curiosity beyond working only on routine activities. Indeed, the thinking process they had acquired assisted in raising many clinical practice questions to explore. Geraldine shared her story relating to Propofol administration in NICU.

> *For example, I remember that during the first clinical placement, almost within 6 weeks, I never found a child who got Propofol. I found it* [Propofol usage] *for adult patients only. But, in the second placement, there was a*

child, with the same case, got Propofol. That's why I was thinking and asked myself. (Geraldine-SN)

In her previous experiences, Geraldine had not administered Propofol to a child. However, when she found out that a child had been given Propofol she started to think whether this action was right or not. She shared this story to demonstrate her critical thinking to an unfamiliar clinical practice she had experienced.

Students emphasized that the CRP model created new behaviours that supported them to think critically about their everyday practice.

This related to my critical thinking. It seemed that even though I did not know for sure, but my mind still thinking "If I don't do this, then this will happen." This model trained us to think. By getting used to small things, we will think about it, and then we will understand it. (Chloe-SN)

Chloe suggests that the CRP model facilitates students' ability to critically think and understand what they had done or what they are about to do. She described the experience of participating in learning the CRP model as being trained to think and this then leads to understanding, rather than just following the routine as discussed earlier.

6.3.2 **Theme 2: Feeling competent in practice**

Reflective practice is known as an effective tool to assist students in their learning process according to their own need. When a student can determine their own learning needs, then it is more likely that the student will feel confident and satisfied with their own learning, and in time feel competent in their practice. In the reflection session, some students shared examples of their experiences in the clinical setting to demonstrate that they were competent. For instance, a student highlighted her competency in suctioning as she said *I did suctioning with confidence,* [I know] *how to prepare the machine, how to positioned the patient* (Heather-SN).

The reflection sessions (data collection) for students were conducted just after they completed the clinical placement period and they discussed their growing confidence and competence in their clinical nursing practice. Not only did they feel more confident and competent they were more satisfied with their practice. These two feelings of confidence and satisfaction are subthemes for this theme of feeling competent in practice as presented in Figure 27.

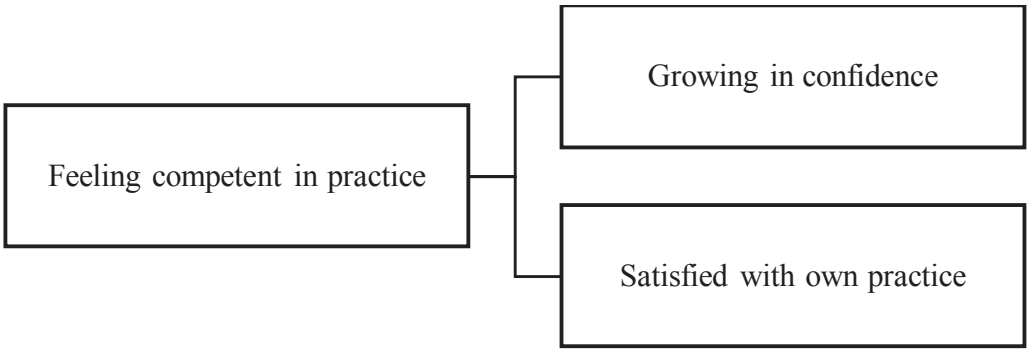

Figure 27. Theme 2: Feeling competent in practice and its sub-themes

6.3.2.1 ***Growing in confidence***

At the end of the clinical practice period, all students were growing in confidence with their ability to reflect on their nursing practice. For some of the students it also encompassed the ability to feel confident in communicating with others:

> *Yes, I felt confident in terms of the experiences related to patient case and the communication skills. I did not have many clinical experiences before. I think, when we feel confident to communicate with others, it describes that we know something. I did try to talk and act something.* (Janet-SN)

Janet talks about being more confident with skills such as communication; as well as growing in confidence as a person and as a nurse. She created a link with a person's confidence and having knowledge to communicate in saying *that we know something*. Geraldine supported this belief, as she mentioned her increasing confidence in responding when in the clinical practice setting as a direct outcome of her increased knowledge.

> *This model can increase my self-confidence. I become more knowledgeable, more understandable. My self-confidence increased. In the beginning, I was worried, but now I am more confident to do things.* (Geraldine-SN)

Elaine and Heather echoed Geraldine's experiences of being more knowledgeable as well as more confident in how they were building upon their experience from the first to the second placement in providing care.

> *For the procedural knowledge, I felt more confident since from the first clinical placement we used articles from journals, so our knowledge was increased. So, in the second clinical placement, we were more confident, more knowledgeable.* (Elaine-SN)

> *In the second clinical placement, I did suctioning with confidence.* [I know] *how to prepare the machine, how to positioned the patient. I had a reflective report about suction in the first clinical placement. One time, there was a code blue situation in the ward. This patient must be suctioned. I suctioned* [the patient] *straight away.* (Heather-SN)

Both students shared their ability to apply knowledge they had learnt from the reflection activities during the first clinical placement period. Having knowledge about clinical practice increased their confidence to participate in the clinical procedure, even in an emergency situation. Their confidence increased over time as they build upon their clinical experience. Here another student shares her clinical practice experiences about deciding whether or not to wean an infant from continuous positive airway pressure (CPAP).

> *I was not confident in CPAP weaning. I was so careful with the criteria. The patient must be in a good condition. Arterial blood gases must be good. No retraction. Oxygen saturation is good. If I found something other than those criteria, I would observe first what other people [doctor or nurse] do. From that, I learned about the process. Then, when my patient's arterial blood gases was good, oxygen saturation was good, minimal retraction but the patient looked not uncomfortable. Like she wanted to pull the CPAP. Long*

> *time ago, I would not dare to wean the CPAP, even though I know that the responsibility to CPAP weaning is 50:50 between the doctor and nurse. I would wait for other people to do an action. However, since I got used to the critical thinking process, I knew that this patient was uncomfortable, then why I didn't try to do an action. I would observe the reaction. And at that time, I weaned the CPAP, supervised* [by the senior nurse]. (Olivia-SN)

Olivia regarded her experience as an example of the development of confidence during the clinical placement period; in the beginning she is very tentative and unsure, *I would not dare to wean the CPAP*. Through using the reflective process and observation *she got used to the critical thinking process* and felt confident to manage the intervention due to her increased knowledge leading her to make clinical decisions and taking action '*I weaned the CPAP'*.

Another student talked about how this increasing confidence enabled her to share her experiences with other students:

> *My skills increased and I believed I changed* [during the clinical practice]. *As a result, I felt confident when I had to do something in the clinical setting. So, when I am going back to my institution, I will be confident if the students ask me about anything relates to my clinical experiences. I can tell them bla bla bla.* (Ella-SN)

Ella not only identifies that she had changed and felt confident, crucially she envisages that she will be able to transfer this confidence into her practice as a clinical educator at the completion of the course. Ella's story provides evidence of her growing in confidence. Reflective activities in the CRP model are deemed to enable this growing confidence in a broad spectrum of the students' development, including communication with colleagues and other health professionals, procedural knowledge, and clinical decision-making.

6.3.2.2 ***Satisfied with own practice***

Besides feeling confident, the majority of students also describe a sense of satisfaction with their clinical practice experiences during the CRP model implementation. Two students described situations in the ward that increased their feelings of satisfaction with their performance communicating with other health team members or patients that enabled a positive relationship with the patient and family.

> *I personally focused on the communication among health professionals. For my project, I need to communicate with some people, because giving nutrition is a collaborative activity with other professionals. I did all the communication, and that made me really understand about the nutrition matters since I read, shared, did all the things…and what made me happier was the reward recognition from other professionals to me.* (Melanie-SN)

> *I had close relationship with some parents, even though they were not my responsibility anymore* [even though the student did not provide direct care to the patient and her family]. (Jessica-SN)

It seemed to mean a great deal for Melanie, as she gained recognition from other professionals, this included a doctor. As in the literature related to masculinity concept, nurses are positioned with a lower status than the doctors. This may explain why Melanie felt happy to obtain recognition following her discussion with the doctor about nutrition for the patients. While Jessica, in her quote, highlighted how she could maintain a *close relationship* with the family even though she was not the nurse caring for the patient and the family. The tone of her voice and facial expressions (during the critical discussion group) created an impression that she was satisfied with her practice and communication with patients and families. These examples were about how students interacted with others in the ward, including other health professionals or family member. According to both students, a positive relationship with others was one aspect of clinical practice that increased their overall satisfaction.

The students' satisfaction was also due to their ability in translating their knowledge into action as described by Isabella.

> *I changed my way of thinking* [in writing the reflective report]. *There was a satisfaction in myself, because I not only understood what had happened, but also I did the action.* (Isabella-SN)

In her story, Isabella shared that she was caring for a child with a fracture who was not provided with the appropriate weight on the skin traction. Following her reflection, she communicated this situation to the doctor and the doctor changed the treatment. She was satisfied with the change as it occurred due to her reflection on the patient case. In the CRP model, the students were asked to reflect on a situation during the clinical practice period. They then wrote about the reflection process. Isabella's quote demonstrates that this reflective writing activity assisted her in gaining an increased understanding on what was occurring in the clinical practice setting.

In comparison, another student shared her experience when she was trying to apply her knowledge into practice:

> *Yes, perhaps sometimes for other people it was simple but we are satisfied with it. Anyway, for me if I've done it, I don't care whether other people are offended or not. I am satisfied because I try to close the gap between theory and practice.* (Sophie-SN)

In her quote, Sophie shared her satisfaction due to her efforts in the clinical practice setting trying to *close the gap between theory and practice*. Her determination to improve her abilities in clinical practice made her ignore the surroundings. However, there is a possibility that her ignorance of others' comments may result in resistant behaviour from the other health member team and missed learning opportunities.

6.3.3 **Theme 3: Creating a safe space**

The benefits of reflective practice went beyond the impact on students' cognitive development, importantly, it impacted students' psychological well-being. In general, students felt more comfortable in their clinical practice following the implementation of the CRP model. These feelings of comfort were attributed to their learning occurring in an environment that was less pressured and often allowed them to guide the learning that they had identified was needed. This creates a safe space for learning which was a very different approach to their experiences during previous clinical placements. One of the reasons for feeling under-pressure in previous clinical placements was due to the clinical educator approach of asking questions that made the students feel that they were undergoing an evaluation (refer to the fourth theme of student nurses in the first AR cycle in Chapter Five). Here a student discussed the different approach used by the clinical educator to facilitate students' learning during supervision process:

> *From the supervision process, they* [the clinical educator]…*tended to hmm they were asking what was my reflection following the care that I gave to the patient.* (Louise-SN)

The quote demonstrates that the clinical educators focused on asking questions related to students' reflections and experiences rather than them driving what has to be learnt or what has been learnt. Further, Louise emphasized the changes in one of the clinical educator's method of asking students questions.

> *Ms. Putri changed. She asked questions according to the reflection steps.* (Louise-SN)

The use of reflection steps and changes in the way questions were asked created a learning atmosphere that was more relaxed and encouraging for the students. This may have assisted students to more freely express or share their learning experiences with the clinical educator. The students highlighted they had started to develop feelings of comfort with the changes occurring in the second clinical placement.

> *For me, there was an improvement in supervisors' behaviour. They were friendlier to the students.* [So I feel] *more comfortable.* (Jackie-SN)

This resulted in a more relational approach occurring between clinical educators and students. While many students discussed this improved approach, not all students felt that way. Emily expressed a different opinion about the clinical educator who provided her supervision where she continued to ask questions as she had done in the first clinical placement period.

> *She* [my clinical educator] *was only* [asking] *general questions. What patient case do I have? What is the disease? What did I do?* (Emily-SN)

During the second clinical placement period, Emily was practicing in the surgical ward. There were two clinical educators responsible for conducting supervision for the students in the surgical ward. One of the clinical educators had expressed her feelings of discomfort with the CRP model. It is likely that the clinical educator did not change her questioning techniques to encourage students to reflect on their clinical practice experiences due to her feelings of discomfort with the CRP model. This description indicates that the student was able to differentiate between what was expected of the clinical educators using the CRP model (facilitative process) and how she was experiencing supervision (evaluative process), suggesting a difference between those who had changed and those that had not changed their approach.

6.3.4 **Theme 4: Courage to speak up**

As the clinical educators changed the supervision process and their role within it, the relationship between the clinical educators and student nurses also changed. Perhaps one of the most pleasing findings of this study was the students' developing the courage to speak, to question the clinical educators and others, and to be confident in doing these more assertive acts. In the first cycle, the students were learning to express their feelings, which can be considered as learning to speak up. Then following the implementation of the revised CRP model, students were no longer

afraid to speak up during the supervision process or when they were in the clinical practice setting. This enabled them to have the courage to participate in the reflective practice session. The students no longer felt under as much pressure to demonstrate their knowledge or that the focus of the sessions was on evaluating their knowledge.

Here Sophie found the courage to speak up in her communication with a doctor:

> *And, that was an achievement for me when a nurse could do things like that* [communicate to the doctor]*, because in rural areas, the doctors are like the king.* (Sophie-SN)

A significant change in behaviour is described in this quote as Sophie was able to speak up not only to nurses in the ward, but also to the doctor. This is a description of a rebalancing of power and position for this nurse. The doctor is a highly regarded professional in Indonesia and the power distance may be even greater than that of student to teacher. Generally many nurses (not only students) would not have the courage to speak up about a patient's condition to the doctor. Another student emphasized this by saying:

> *For example, we had a courage to conduct collaboration action.* (Andrea-SN)

The meaning of collaboration action in this quote is when the student communicated about her patient case to the doctor in the ward. It is common in Indonesia that student nurses are rarely in contact with the doctor. Therefore, Andrea felt satisfied when she had the courage to communicate with the doctor.

The courage to speak up is like a culmination of the students' learning and confidence developing in the clinical setting. This may well be related to their ability to reduce the influence of collectivist in the clinical setting. The key to this was having the knowledge gained through the reflective activities as these students suggested:

> *So having knowledge first is important, added with experiences.* (Isabella-SN)

That means that I told them, the in-charge nurse and the doctor, even the supervisor, as easy as that. I mean I had the courage since I got this [information from the literature]. (Grace-SN)

The students' quotes assert that there is a link between conducting reflection, finding related information, developing understanding and gaining confidence. This process can be achieved if the students are able to think critically during their clinical practice placement.

The findings from the student nurses' data reinforced the positive benefits of the CRP model for them during their second clinical placement period. The students used their increased communication skills to discuss their experience and knowledge about clinical practice; as a result they were able to participate in more meaningful learning experiences. Importantly, with their increasing confidence they were able to act as patient advocates when they recognised that practices used were not the most up-to-date. The experiences the students gained during their clinical practice created feelings of competence and confidence as nurses.

6.4 Findings from the Evaluation Session

An evaluation session with the student nurses was held six weeks after the clinical placement was completed. This session explored student nurses' perspectives on reflection and reflective practice in general. Flash cards were used as a tool to assist students in sharing their perspectives (see Methods section in Chapter Three for further details). Findings of this evaluation have been prepared in a manuscript and are currently under review process by the Nurse Education Today journal. The following section provides the full manuscript of the paper. Please note that the pseudonyms given to the participants in this paper differ from the names given to the throughout the rest of this thesis. In this paper they have been allocated Indonesian names as they did not need to be differentiated from the clinical educators.

Using Flashcards to Engage Indonesian Nursing Students in Reflection on Their Practice

ABSTRACT

Background: Reflective practice is now widely used as a critical learning tool in undergraduate and postgraduate nursing programs in most developed countries. However in developing countries, reflective practice is in its infancy.

Aim: To introduce reflective practice to postgraduate students in an Indonesian nursing education institution. This paper presents the positive meanings of reflection and reflective practice experienced by the students and the way they used reflection within their practice.

Design: A descriptive qualitative study was conducted to explore the meaning of reflection or reflective practice using flashcards.

Method: A clinical reflective practice model taking into consideration Indonesian culture was developed and applied during students' clinical placement. A few weeks post clinical placement, 21 students participated in an evaluation session. The meaning of reflection or reflective practice was explored using flash cards containing images of people and environment with different situations and events. Students were asked to choose a card that represented their viewpoints about reflective practice and share it with the group. Data were digitally captured and analysed using thematic analysis.

Findings: Reflection provided a positive experience for the students. In their own words, they discussed their journey of using reflection during the clinical placement period. The use of reflection was identified as expanding their view of nursing practice, providing a safe place to explore their experiences and clarity when they encountered challenging situations during their clinical practice. Reflecting on practice experiences resulted in increased self-awareness, and enhanced their learning.

Conclusion: The findings indicate that reflective practice can be implemented successfully in Indonesia and may have value for other Eastern countries that share similar cultural characteristics. The use of flash cards assisted the students describe through stories their experiences of participating in this reflective practice program.

Keywords: Reflection; model; student; creative; flashcards; Eastern; Indonesia

BACKGROUND

In nursing, reflective practice is widely used as a critical learning tool in undergraduate and postgraduate nursing programs in most developed countries (Glaze 2001; Wilding 2008). However in developing countries, its use is at a beginning stage in undergraduate nursing programs (Ip et al. 2012; Stockhausen & Kawashima 2002). The literature demonstrates that student nurses gain significant benefits from reflection (Bulman, Lathlean & Gobbi 2012).

The term 'reflection' was coined by Schön (1983) , who developed the theory of reflective practice, based on Dewey's philosophy about how a person thinks about something i.e. an event or situation (Dewey 1998) , indeed for a spontaneous action (Schön 1983). Reflection involves a process of looking back on the action taken in order to think thorough whether the action was effective or not (Jasper 2011). This type of learning is important in a field of study that contains professional knowledge, such as nursing. Schön (1983) emphasizes that professionals often face uncertain situations in their practice, and reflection assists them to be more aware of their own practice. Schön (1983) states that *reflection-on-action* and *reflection-in-action* are two types of reflection that facilitate learning during professional education. *Reflection-on-action* is when the reflection process is undertaken on completion of an action, whilst *reflection-in-action* is reflection undertaken during the action (Schön 1983). When reflection is used in practice, it is called reflective practice.

Reflective practice in nursing education

Nursing scholars have identified the positive impact on nursing education following the implementation of reflective practice. In undergraduate programs, reflective practice has been seen to improve student nurses' development during clinical practice placement (Lie et al. 2010). In another study examining structured reflective practice, Glynn (2012) found that whilst students' self-confidence rates decreased slightly, they increased their insightfulness about both their knowledge and skill level. Reflection assists in transformation of student nurses' behaviour in terms of self-awareness and self-confidence as a nurse (Glaze 2001) and enhances students' thought processes during clinical placement (Durgahee 1996). Despite the fact that

some Eastern countries have started to implement reflective practice in their nursing curriculum, the majority of studies related to reflective practice or reflection in the literature were conducted in Western countries.

The implementation of reflective practice in eastern countries

Eastern countries such as China, Indonesia, and Japan have started to integrate reflective practice into their curriculum (Ip et al. 2012; Kuswandono 2014; Stockhausen & Kawashima 2002). Challenges were identified that needed to be resolved for successful reflective practice implementation. A major issue is the different cultural characteristics of Eastern countries compared to Western countries (Stockhausen & Kawashima 2002). This has resulted in the influence of culture becoming a contested and debated issue among scholars in Eastern countries, particularly in Asia (Joyce-McCoach et al. 2013).

Based on Hofstede's culture dimensions, Wanda, Wilson and Fowler (2014) note that there are four culture dimensions of Eastern countries that relate closely to reflective practice: (1) high power distance, (2) strong uncertainty avoidance, (3) collectivist and (4) masculinity. High power distance refers to the wide gap between educators (regarded as having a higher power position) and students. Hofstede (2011) suggests that strong uncertainty avoidance may result in insecure feelings when confronted by ambiguous situations such as learning a new skill. The collectivist viewpoint may result in prioritising group interest before individuals interest (Hofstede 2011), while masculinity relates to the concept of men being more dominant and visible than women. Each of the cultural dimensions potentially influences the implementation of reflective practice in Eastern countries. For instance, Indonesian people may not be able to discuss their personal feelings or thoughts as this may be regarded as focusing on self rather than the group (Kuswandono 2014). Similarly, Ip et al. (2012) found that Chinese students were resistant to sharing their reflections openly with their peers or educators, even if this assists in increasing students' critical thinking abilities.

This paper will now focus on the implementation and evaluation of a reflective practice model in a postgraduate nursing program in Indonesia. Table 1

provides examples of how the cultural dimensions relate to the education setting of this study in particular high power distance, collectivist and uncertainty avoidance. Masculinity has not been included as it was thought to have limited if any influence as the nursing workforce, the educators and the students were all female.

Table 1. *Culture dimensions and its relation to reflective practice*

Culture Dimensions	Example of Culture Dimension in Education Setting	Possible Impact of Culture Dimensions to Reflective Practice	Strategies Used to Reduce Impact of Culture Dimensions when Implementing Reflective Practice
High power distance	A teacher will have more power than students in the learning process (Kim & Cha).	Students are unlikely to initiate reflection to improve their own learning as they believe that it is the teacher's responsibility to make them learn.	Student-centred learning Regular reflective discussion Group discussion
Stronger uncertainty avoidance	Avoidance behaviour in uncertain clinical situations (Ekintumas 1999), therefore students prefer a structured and detail information.	Students avoid new experiences related to using reflective practice or reflection.	Structured reflection Clear guidelines on reflective activities
Collectivist	Students are hesitant to speak up if it will break the group's harmony or to challenge the teacher (Burnard & Naiyapatana 2004).	Less chance that the students will conduct reflections since they will be viewed as 'different' amongst their group.	Group discussion Regular individual reflective report Written feedback

(Summarised from Wanda, Wilson & Fowler 2014)

METHOD

Research approach

An action research (AR) project was conducted to develop and implement a Clinical Reflective Practice (CRP) model for clinical educators and student nurses in a postgraduate nursing program in Indonesia. This new model integrated reflective practice with Indonesian cultural characteristics (high power distance, collectivist,

and uncertainty avoidance) in its design. The CRP model was introduced to the educators and students prior to commencement of the one-year clinical placement. This paper reports on the findings from students perspectives of using the model. Data was collected 6 weeks after completion of the clinical placement. Other aspects of this project, such as the experiences of clinical educators and evaluation of the new model, will be published in separate journal articles.

To assist the students during the implementation of the CRP model, a structured format was developed based on data collected from cycle 1 of the study which consisted of 5Ds: doubt, description, dissection, discover, and decision. It was anticipated that the weekly reflective report using the structured format would assist the students in overcoming uncertainty avoidance (or insecure feelings) that might occur during their writing process (Wanda, Fowler & Fowler, 2014). The intention of the format was to decrease students' uncertainty feelings as they knew what was expected of them in the reflective activities (Ip et al. 2012). Students were encouraged to use the structured format and to submit a weekly reflective report to their clinical educator.

The clinical educators facilitated group discussions using the students' reflective reports to minimize the impact of high power distance on interactions between the students and educators'. The students also held student led reflective group discussions in order to reduce the possible impact of collectivism by balancing individual learning needs with the overall needs of the group. The use of structured reflection, frequent individual reflective reports and group discussions are strategies used in this study to overcome the possible impact of cultural dimensions on reflective practice.

Design

A descriptive qualitative study design was used to explore the students' experiences of reflective practice. This approach is generally based on principles of constructivist inquiry (Polit & Beck 2014) whereby the meaning of a situation is constructed from participants. The use of flashcards (picture cards showing images) was chosen as a creative tool to assist participants in sharing their experiences in a relaxed and fun

environment and in order to minimize the influence of high power distance dimension that may be present when capturing data in this setting. Titchen and Horsfall (2011) claim that picture cards can be used as a means of sharing values, feelings and experiences. This method has not been used with Indonesian student nurses at this faculty prior to this study and it was thought to be an excellent opportunity for them to experience a creative evaluation method.

Participants

The researcher invited the 23 students who undertook the Paediatric Nursing Specialist Program to participate in an evaluation session scheduled six weeks after they completed their final clinical placement. Twenty-one students agreed to participate in the session. The supervisors of the researcher (authors 2 & 3) were in Indonesia at the time and were invited to attend the evaluation session. The students used reflections throughout their clinical placement year. All participants were female aged 27-40 years old. Most students were employed as clinical educators in a tertiary institution from provinces across Indonesia. No student had knowledge of reflective practice or had used reflection prior to the study.

Data Collection

The cards were placed in the middle of the room and students were asked to pick a card that captured their thoughts and feelings about reflective practice or reflection. Once they had selected a card the principal researcher (1st author who is an Indonesian educator), asked each participant to use the cards as a way of sharing their experiences of reflective practice and reflection and what it meant to them. In the discussion, some students chose to speak in English and others in Indonesian. This 2-hour-discussion was audio recorded and transcribed. Data were de-identified to ensure participant confidentiality was maintained and then translated into English.

Data Analysis

Thematic analysis was undertaken to identify, analyse and report patterns or themes within the data (Braun & Clarke 2006). The approach required becoming familiar

with the data, generating codes, searching for and reviewing themes, defining and naming themes (Braun & Clarke 2006). All authors read the transcribed data generated from the participants' stories about the meaning of reflection or reflective practice. After reading and reviewing the data a number of times, codes were generated and five themes were identified from the students' experiences of using reflection during their clinical placement period. The researchers participated in a critical discussion to confirm these final themes.

Rigour

Rigour of this study was achieved using several strategies such as prolonged engagement, reflexivity, member-checking, and audit trail. In this study, the principal researcher had been in contact with the students during the model implementation (1 year). Prolonged engagement with the participants in action research became a strategy to achieve credibility of the study findings (Lincoln & Guba). During the interaction, the first author frequently examined her relationship with the students to prevent the effect of power which might exist in the relationship with the students; this refers to reflexivity (Hall & Callery 2001). As the study progressed the students became more confident in speaking up and in sharing their opinions with one another and with the educators and researcher, thereby indicating a reduced influence of high-power distance. However in order to minimize the potential impact of high power distance between the students and the researcher, member-checking was conducted after the students had completed their clinical placement to ensure that the findings came from the data (Tobin & Begley 2004). The final themes were sent to the six students for review, they all responded and verified that the themes had emerged from their stories of reflective practice. A researcher diary was used to record the research process and provided an audit trail including capturing the decisions made during the research project.

Ethical Considerations

This research project was granted ethical approval from the two university Human Research and Ethics Committees where the authors either study and/or work. All

participants were provided with information sheets and attended information sessions prior to gaining their signed consent to participate in the study.

FINDINGS

The findings of this study relate to students' experiences of using reflection in their clinical practice. Five themes emerged: expanding their views, safe place, a light in the dark, self-awareness booster, and learning through experience. Direct quotes from the participants (given pseudonyms) are used to highlight each theme. The themes portray a journey taken by the students during the year in which the reflective practice model was implemented.

Expanding their views

The reflective practice model assisted students to enhance development of knowledge and skills during their clinical placement period. They started to use reflection to expand their clinical practice knowledge and to explore practice in a clear and effective manner. Reflection was depicted as human eyes that allow us to see the world and even an owl's eyes that enable you to sharpen your vision.

> *God gives us two eyes to see the unlimited world... Reflection is like 'two eyes' to learn unlimited knowledge.* (Wulan)

> *Reflection assists* [me] *to look deeper on something* [that] *happens, just like an owl's eyes.* (Alya)

Reflection assisted the students in examining an experience or incident with clearer vision. Indeed, the students thought that they obtained more knowledge than they expected after involvement in reflective activities due to their expanded view on what had occurred.

> *Reflection is like an effort that you should do if you want to get something better. The analogy is like when you want to see more views, you will go to the top of the house. In fact, you might see more views than you have expected.* (Sri)

The student through her image of the view from the *top of the house* has made the link between one of the main outcomes of reflective practice - enabling the student to step away from the experience, and observe and critique it as an objective outsider. In other words, expanding her view might be considered as an outcome of the students' critical thinking and questioning about the things she takes for granted in everyday practice.

Safe place

A number of students faced some challenging times during their clinical practice period relating to the clinical environment or routine activities they encountered every day. These conditions sometimes made the students feel overwhelmed and uncertain. Reflection was viewed as a 'safe place' with students gaining comfort post reflection. This was due to the opportunity for them to release their stress through writing the reflective report, and resulted in them feeling better about the situation.

> *Reflection is like a comforter after having routine activities.* (Ayu)

> *Home is a safe place for me, when you feel comfort in there. That's what I felt after the implementation of reflective practice because I get so many positive things from reflection… results in increased self-confidence.* (Nada)

Accordingly, after reflecting on her practice, Tiara felt more refreshed and gained more positive energy as she explains:

> *After writing each reflective report, I enjoyed and was more enthusiastic with my practice. In the beginning, I felt stress with the hospital environment, but reflection helped me identify what I can do to the patient and family…The analogy of reflection is like people who just had their vacation and re-charge their energy. I feel fresh and enthusiastic to start my next clinical placement.* (Tiara)

We can see from this quote that Tiara is using reflection as a way of de-stressing about past situations and building her resilience to move into a future placement. Another student described reflection as:

...a mind and spiritual adventure. (Risa)

The concept of reflection being an adventure potentially enables students to make sense of and expand their practice experience. It can be inferred that reflection was a beneficial activity that assisted students to understand and learn from challenging clinical experiences. It was like a safe and enjoyable place wherein they felt comfortable; a form of professional self-care.

A light in the dark

Students through their stories illustrated the use of reflection and reflective practice as a significant aid in their knowledge development. Reflection provided them with a light in the dark.

> *Reflection is a little thing. Yet, like lots of little lights that can brighten a dark room, I become a more knowledgeable person because of reflections.* (Diana)

Reflection enabled the students to see-more clearly (the light) as a means to increasing and sharpening their knowledge. This was echoed by another student:

> *Reflection has the same meaning with when I light a candle to brighten a dark room… The more candles you have, the brighter room you get… Moreover, not only you who can light the candle, your friend can also light the candles, so you will have more and more candles.* (Metha)

In the above quote, the lighting of candles was used as a metaphor for knowledge acquisition. The student states that *the more candles you have, the brighter room you get.* Shared reflection as part of a group discussion was identified as being more likely to have increased benefits. The sharing of different perspective coming from varied experiences has the potential to significantly enrich the students' learning process.

Self-awareness booster

At the end of the clinical placement period, students felt more knowledgeable, and had increased feelings of self-satisfaction. Such feelings emerged when they became more aware of themselves. Reflection acted as a self-awareness enhancer in the clinical practice setting which facilitated students to think critically about their own practice. In this story drawn from a picture of a boat the student emphasises that reflection increased her self-awareness:

> *My reflective report is like a well-anchored boat in a port because at the moment I am fully aware of all of my activities, why I do something, or do all the care benefit the patient.* (Dara)

This valuing of reflection as a self-awareness tool is anticipated to encourage students to continue using it as part of an ongoing learning process even when they have completed their clinical practice experience. The student in the next quote draws on her existing experiences:

> *A canoe is a tool to sail on the lake. Even though I am a knowledgeable person in sailing, I still need to be aware of my ability because there are lots of things that need to be explored continuously.* (Acha)

Acha uses the canoe (*a tool to sail on the lake*) as a metaphor for reflection, as a tool for learning. She recognises her knowledge level but is aware of the need for learning to be a continuous activity. In the next quotes, Lia and Lilis describe the benefit of reflection in facilitating their thinking process in the clinical setting.

> *During reflective practice in a paediatric ward, I sometimes reflect on a child's response, touch, or behaviour. It stimulates me to explore more and analyse deeper about my tasks, which lead to become fully aware and knowledgeable of the tasks.* (Lia)

> *...Reflection assists in finding which action is the best, and aware of that action.* (Lilis)

Reflecting on their practice enabled them both to think more critically about their actions and how this might impact on the patient. Lia shares that her reflection-in-action assisted her in understanding the experience of the child in the ward. She recognises the value of reflection in enhancing her clinical practice and knowledge resulting in increased self-awareness. Following the use of reflection, Lilis was more aware of her own practice which enabled her to think about and then take the best action to suit the issue she was dealing with.

Learning through experience

The following quotes provide rich images to describe the students' experiences of using reflection to assist them in learning from their clinical experiences.

> *A fear of sea waves can be reduced if you have more experiences being at the beach. Likewise, fears of clinical practice can be eliminated when you have more experiences, and reflection helps you to learn from that experience.* (Rina)

Reflection assisted Rina to learn and to reduce her fears by learning from clinical experiences. Another important benefit from reflection was that it assisted in understanding knowledge that was 'unclear':

> *The part of this picture* [a mountain] *is dark, covered with clouds, and the other side is bright and clear. Knowledge has a clear and unclear side. Using reflection, we can make something clearer.* (Nirmala)

In the quote, Nirmala has provided abstract images that are easily related to by most people, sea waves and mountains. Linking these images with reflection demonstrates the potential power of learning that can occur in reflective practice, particularly in facilitating students to think more critically about their experiences and how they can gain deeper knowledge from this process. To summarize, the use of flashcards as a means of sharing, facilitated students to express their perspectives on reflection and reflective practice in a fascinating and meaningful way.

DISCUSSION

Value of reflection

Findings were positive from the students' perspective regarding reflection and reflective practice. All students acknowledged that they benefitted from learning to use reflective practice. Reflection facilitated the development of knowledge and skills through a process of deeper exploration of their experiences. It has similarities with Bulman, Lathlean, and Gobbi's (2012) findings where reflection assisted students to make sense of clinical practice. The most appropriate time for reflective practitioners to learn from their experiences is when they are in practice (Rolfe 2014). In other words, reflection acts as a tool for learning, resulting in knowledge expansion relating to their own experiences in practice (Ip et al. 2012).

It is noteworthy that reflection provided a 'safe place' for students when they faced 'hard times'. Delany and Watkin (2009) emphasize that reflection is regarded as 'a break' from the clinical setting, giving students time to think thoroughly about what had occurred during clinical practice, either individually or in groups. Group discussion provides additional benefits for students (Holmlund, Lindgren & Athlin 2010), whereby students are able to share their experiences and thoughts and gain support from group members who had similar experiences (Gould 2011).

Findings from this study also demonstrated that students' self-awareness has increased following their reflective activities, with one student describing the reflective report as *a well anchored boat in a port* which facilitated her self-awareness. Reflection facilitates the students to be more aware of their own practice (Bulman, Lathlean & Gobbi 2012). Students' critical thinking processes became clearer as the result of this study. They used reflection and questioning to challenge one and another about everyday nursing routines and rituals. In doing so, they became more critically aware of their own practice.

Influence of culture

In this study, students obtained positive experiences from reflective practice. The possible influences of culture on reflective practice (as described in Table 1) were anticipated and actively addressed by considering Indonesian culture characteristics. High power distance was overcome by regular reflective activities which assisted students to be more knowledgeable and confident. As Erden (2013) asserts unequal power distribution is due to different position, status, or education. Another strategy to reduce high power distance was group discussion where students took the lead in their learning process without the clinical educators' intervention. Group discussions can also minimize the impact of collectivism as the students were able to share their reflection with peers who had the same objectives to achieve (Devita 2000). They felt valued and supported in the group discussion (Manning et al. 2009) and as Metha (a student) said '*the more candles you have, the brighter room you get'* describing the benefit she gained from group discussions.

Stronger uncertainty avoidance was lessened by the use of the structured reflection template (5D's), similar to findings from Ip et al. (2012) regarding the benefit of using a structured reflection template with Chinese students. However, Ip et al. (2012) indicated that despite lessening uncertainty avoidance students were still reluctant to share thoughts with their clinical educators or peers. This may be related to high power distance between the students and their educator. Another possible reason is related to collectivism, which may have prevented the student from appearing to be different amongst their peers. Similarly, Kuswandono (2014) found that superficial reflection occurred in Indonesian students as a result of avoidance behaviour related to being seen as different. However, Kuswandono managed to reduce the influence of this by providing group discussion. Accordingly, the use of group discussion in the current study lessen the impact of collectivism within the students.

The use of flashcards

Flashcards were an effective and creative tool to explore students' perception and experiences of using reflective practices. In the beginning of the session, the students

looked confused about this method. This is an example of uncertainty avoidance occurring when the students encounter a situation that they have never experienced before. Furthermore, having all the researchers in the room (related to power distance characteristic) may have impacted on their initial level of engagement, resulting in them being hesitant in selecting a card or speaking up in the beginning. However, when a number of students started to share stories about using reflection, other students quickly gained confidence and were eager to share their stories. The cards helped them to overcome the power distance as they had a choice about which card best reflected their experience and they were able to tell their story by referring to the images on the cards.

Visual images can be used to construct meanings of experience and assist in the exploration of different meanings (Patton, Higgs & Smith 2011). We were thrilled to see how the students used the cards to reflect on their experiences in a confident and open manner and the very creative connection they made between metaphors, their reflections and their stories. The images in the cards may have fostered students' insight into their reflective practice experiences, resulting in a richness that may not have been achieved without the use of the cards. As Mitchell (2008) emphasizes, visual images produce an extensive range of issues and topics in an inquiry.

Practical strategies such as using structured reflective writing, providing clear guidelines and employing creative tools in evaluating the students' experience are essential in ensuring successful implementation of reflective practice in Eastern countries. These practical strategies can heighten acceptance of reflective practice in countries which have certain culture characteristic such as high power distance, collectivist, and strong uncertainty avoidance.

LIMITATION

Findings of this study (in Indonesia) need to be understood in relation to the context in which they are to be implemented. Most Eastern countries shared quite similar culture characteristics, however, each Eastern country may has specific culture characteristics such as the concept of 'losing face' in China, which refers to avoiding

arguing with someone (Chiang, Chapman & Elder 2010) or the concept of 'kreng jai' in Thai which refers to not complaining about something because it can make other people uncomfortable (Burnard & Naiyapatana 2004) that need to be taken into account. Consideration therefore needs to be given to cultural and context factors when adapting reflective practice models for use in Eastern countries.

CONCLUSION

This study was a part of a larger project which implemented a reflective practice model tailored to Indonesian cultural characteristics in order to minimize the influence of high power distance, collectivism and stronger uncertainty avoidance, three dimensions of culture commonly found within the societies of Eastern countries. By using flashcards, a creative tool to explore meanings, the study revealed the experiences of student nurses and the value they found in using reflection. Findings indicated how reflection provided many benefits to them, such as learning from experience, expanding their clinical practice knowledge, providing a safe place and a light in the dark during hard times in the clinical setting. Reflection increased their self-awareness and enhanced the learning process. Indeed, it is anticipated students involved in this research, who are employed as nurse educators, will use reflection to enhance their education practice and to support students in their own institutions to develop their reflective abilities, thereby translating what they have learned and gained from this experience into their practice settings.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

Bulman, C., Lathlean, J., & Gobbi, M. (2012). The concept of reflection in nursing: Qualitative findings on student and teacher perspectives. *Nurse Education Today, 32*(5), e8-e13. doi: http://dx.doi.org/10.1016/j.nedt.2011.10.007

Burnard, P., & Naiyapatana, W. (2004). Culture and communication in Thai nursing: a report of an ethnographic study. *International Journal of Nursing Studies, 41*(7), 755-765. doi: http://dx.doi.org/10.1016/j.ijnurstu.2004.03.002

Chiang, C.-K., Chapman, H., & Elder, R. (2010). Changing to learner-centred education: Challenges experienced by nurse educators in Taiwan. *Nurse Education Today, 30*(8), 816-820.

Delany, C., & Watkin, D. (2009). A study of critical reflection in health professional education:'Learning where others are coming from'. *Advances in health sciences education, 14*(3), 411-429.

Devita, G. (2000). Inclusive approaches to effective communication and active participation in the multicultural classroom An international business management context. *Active learning in higher education, 1*(2), 168-180.

Dewey, J. (1998). *How we think: a restatement of the relation of reflective thingking to the educative process*. Boston: Houghton Mifflin.

Durgahee, T. (1996). Promoting reflection in post-graduate nursing: A theoretical model. *Nurse Education Today, 16*(6), 419-426. doi: http://dx.doi.org/10.1016/S0260-6917(96)80048-7

Erden, N. S. (2013). Power Distance Leads to Corporate Grapevine: The Mediating Role of Perceptions of Uncertainty. *Journal of Multidisciplinary Research, 5*(1), 95.

Glaze, J. E. (2001). Reflection as a transforming process: student advanced nurse practitioners' experiences of developing reflective skills as part of an MSc programme. *Journal of Advanced Nursing, 34*(5), 639-647. doi: 10.1046/j.1365-2648.2001.01793.x

Glynn, D. M. (2012). Clinical judgment development using structured classroom reflective practice: A qualitative study. *Journal of Nursing Education, 51*(3), 134-139. doi: http://dx.doi.org/10.3928/01484834-20120127-06

Gould, B. (2011). Role of reflective group discussions in the development of nursing skills. *Mental Health Practice, 14*(8), 32-33.

Hall, W. A., & Callery, P. (2001). Enhancing the rigor of grounded theory: Incorporating reflexivity and relationality. *Qualitative Health Research, 11*(2), 257-272.

Hofstede, G. (2011). Dimensionalizing cultures: The Hofstede model in context. *Online Readings in Psychology and Culture, 2*(1), 8.

Holmlund, K., Lindgren, B., & Athlin, E. (2010). Group supervision for nursing students during their clinical placements: Its content and meaning. *Journal of nursing management, 18*(6), 678-688.

Ip, W. Y., Lui, M. H., Chien, W. T., Lee, I. F., Lam, L. W., & Lee, D. T. (2012). Promoting self-reflection in clinical practice among Chinese nursing

undergraduates in Hong Kong. *Contemporary Nurse, 41*(2), 253-262. doi: 10.5172/conu.2012.41.2.253

Jasper, M. (2011). *Vital notes for nurses: Professional development, reflection and decision-making* (Vol. 17): John Wiley & Sons.

Joyce-McCoach, J. T., Parrish, D. R., Andersen, P. R., & Wall, N. (2013). Unlocking reflective practice for nurses: Innovations in working with master of nursing students in Hong Kong. *Nurse education in practice, 13*(5), 388-392. doi: http://dx.doi.org/10.1016/j.nepr.2012.11.002

Kuswandono, P. (2014). University mentors' views on reflective practice in microteaching: Building trust and genuine feedback. *Reflective Practice*(ahead-of-print), 1-17.

Lie, D., Shapiro, J., Cohn, F., & Najm, W. (2010). Reflective practice enriches clerkship students' cross-cultural experiences. *Journal Of General Internal Medicine, 25 Suppl 2*, S119-S125.

Manning, A., Cronin, P., Monaghan, A., & Rawlings-Anderson, K. (2009). Supporting students in practice: An exploration of reflective groups as a means of support. *Nurse education in practice, 9*(3), 176-183.

Mitchell, C. (2008). Getting the picture and changing the picture: visual methodologies and educational research in South Africa. *South African Journal of Education, 28*, 365-383.

Patton, N., Higgs, J., & Smith, M. (2011). Envisioning visual research strategies. In J. Higgs, A. Titchen, D. Horsfall, & D. Bridges (Eds.), *Creative spaces for qualitative researching: Living research*. Rotterdam: Sense Publisher.

Polit, D. F., & Beck, C. T. (2014). *Essentials of nursing research: Appraising evidence for nursing practice* (8th ed.). Philadelphia: Lippincott Williams & Wilkins.

Rolfe, G. (2014). Rethinking reflective education: What would Dewey have done? *Nurse Education Today, 34*(8), 1179-1183.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action* New York: Basic Books.

Stockhausen, L., & Kawashima, A. (2002). The introduction of reflective practice to Japanese nurses. *Reflective Practice, 3*(1), 117-129.

Titchen, A., & Horsfall, D. (2011). Embodying creative imagination and expression in qualitative research. In J. Higgs, A. Titchen, D. Horsfall, & D. Bridges (Eds.), *Creative spaces for qualitative researching: Living research*. Rotterdam: Sense Publisher.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388-396.

Wilding, P. M. (2008). Reflective practice: A learning tool for student nurses. *British Journal of Nursing, 17*(11), 720-800.

6.5 Summary

During the second AR cycle the clinical educators and students used a more structured CRP model and reflection template. The student nurses and most of the clinical educators found it easier to implement this more structured approach. Changes in confidence, communication and clinical practice were clearly identified outcomes for both the clinical educators and the student nurses. The student nurses became even more self-directed in their learning as they actively investigated information that addressed their clinical concerns.

From the clinical educators' reflections, themes were identified portraying their struggle to become accustomed to the CRP model. They discussed their feelings toward the model and in changing practice during the second clinical placement. To some extent, this might be due to cultural influences on the implementation of reflective practice and how it impacts on their role as clinical educators. Nonetheless, most clinical educators stated they were experiencing positive changes occurring in the behaviour of the student nurses and their approach to learning, as well as adopting to the model and learning for themselves.

Meanwhile, the student nurses described positive experiences when they felt comfortable and more competent during their second clinical placement. Their stories reinforced increasing clinical expertise. The positive experiences they gained from using the CRP model were still evident long after the practice period was completed as outlined during the follow-up evaluation session conducted six weeks post the clinical placement period.

In the next chapter, an overarching analysis of the findings from the second AR cycle describes the interrelated themes between the clinical educators and the student nurses' experiences.

Selama siklus kedua RA, pembimbing klinik dan mahasiswa keperawatan menggunakan model PiKiR dan refleksi yang lebih terstruktur. Oleh karena itu,

mahasiswa keperawatan dan sebagian besar pembimbing klinik merasa lebih mudah untuk mengimplementasikannya. Pendekatan yang lebih struktur ini membawa perubahan pada rasa percaya diri, kemampuan komunikasi, dan praktik klinik pembimbing dan mahasiswa keperawatan. Mahasiswa menjadi lebih mandiri dalam menentukan arah proses pembelajarannya sendiri karena mereka yang menentukan informasi apa yang ingin mereka pelajari lebih lanjut.

Dari refleksi pembimbing klinik, tema yang muncul menggambarkan tantangan yang mereka hadapi untuk terbiasa dengan model PiKiR ini. Hal ini tergambar pada diskusi tentang perasaan mereka terhadap model PiKiR dan perubahan praktik yang mereka jalani sebagai pembimbing klnik selama praktik klinik mahasiswa periode ke-dua. Dalam beberapa hal, alasan yang berhubungan dengan hal ini terkait kemungkinan tantangan budaya pada konsep praktik reflektif dan bagaimana hal ini berdampak pada perannya sebagai pembimbing klinik. Namun demikian, pembimbing klinik menyatakan bahwa mahasiswa mengalami perubahan yang positif terkait dengan perilaku dan pendekatan mereka dalam proses belajar.

Sementara itu, mahasiswa keperawatan mendeskripsikan pengalaman positif mereka. Mahasiswa merasa nyaman dan lebih kompeten pada periode praktik klinik yang ke-dua ini. Hal yang mereka sampaikan menguatkan bahwa ada peningkatan kemampuan klinik dalam diri mereka. Lebih lanjut lagi, pengalaman positif yang mereka dapatkan dari penggunaan model PiKiR ini masih tetap ada bahkan setelah periode praktik klinik selesai, seperti yang tergambar dalam sesi evaluasi yang dilaksanakan enam minggu setelah praktik klinik selesai.

Pada bab berikutnya, analisis mendalam terkait temuan pada siklus kedua RA yang menggambarkan hubungan antara tema pembimbing klinik dan mahasiswa keperawatan akan disampaikan.

7 Interconnectedness of Data

7.1 Introduction

The previous chapter describes themes that were identified from the clinical educators' and the student nurses' data collected during the second AR cycle when the revised CRP model was implemented. A connection between the clinical educators' and students' experiences became obvious during the initial analysis process. This resulted in further analysis of the data to highlight the shared experiences of the students and the educators focusing on the developing understanding and use of the CRP model. This chapter presents the findings of this analysis. Three themes were identified: learning to walk; finding your feet; and taking a stand. Each theme is outlined in the following section with quotes from the clinical educators (Indonesian names assigned) and student nurses (English names assigned) used to highlight how each theme relates to their overall experience. This is followed by a summary of the overarching analysis to conclude the chapter.

7.2 Learning to walk

Learning to walk describes a situation where someone is in a process of learning a basic skill; the basic skill that will determine and support their ability to achieve the next complex task. In regard to the CRP study, this theme describes situations where the clinical educators and student nurses were learning to use the CRP model and were mindful of its impact on their practice. As a child learns to walk they will experience periods where they have feelings of being challenged and uncertain and also of being successful. The clinical educators and student nurses also experienced these periods of uncertainty, challenge and success, in implementing the CRP model.

A significant outcome of the CRP study was the acknowledgment by the clinical educators and student nurses of the changes in their own (and others) practice as a result of the process they were involved in to learn how to use the CRP model. There was a shift in the role of the clinical educator; from a supervisor or assessor into a facilitator of learning. The main difference between those two roles is that being a facilitator, the clinical educator uses a more exploratory and questioning approach to support the students' learning; rather than focusing on questioning the students in order to identify what the students had learned or what they know about topics related to the clinical learning objectives. Examples of the questions being asked included:

> *She asked questions according to the reflection steps. What have you learned since last week? What will you plan for the future?* (Louise-SN)

> *…what my experiences were so far? What I would do in the next days? Then, asking whether I have searched the literature or not.* (Ella-SN)

From the quotes above, it can be seen that the clinical educators used more exploratory questions demonstrating that they were not only using the revised CRP model they were focusing on the key elements within it and expanding the student's information finding skills – *asking whether I have searched the literature or not*. This was confirmed by the clinical educators themselves as they spoke of changing their questioning.

> *Previously, we didn't know about how to ask the question about certain aspects. How to explore or stimulate students to think as we expected.* (Ayu-CE)

> *For example* [previously] *when I came to the hospital I asked "Which one is your patient?" or "Tell me about your patient." I never asked "Do you have any problem?" or what the students learned after the experiences.* (Putri-CE)

The use of exploratory questions created a different learning dynamic where the focus was less on student assessment or being judged and more on the clinical

educator establishing the learning needs of the student during the supervision session. This change in approach by the clinical educators created a space for the students to explore their clinical experiences and the learning that was occurring for them; as when a child learns to walk they also learn from their experiences. Further confirmation related to the safe space for students in the CRP study were provided in the evaluation session conducted with the students six weeks after the clinical placement was completed. The students discussed how they felt about the ways in which the clinical educators were changing their practice as highlighted in the following quotes:

> *When Ms. Putri asked me questions, how she asked the question was really good. I did not feel under-pressure. I felt that I could tell her everything.* (Grace-SN)

> *When I compared my clinical practice this semester to the previous one, I felt more comfort in this semester.* (Olivia-SN)

Both quotes emphasize that the students found a more relaxed and safe space to learn in the second clinical placement which may have been due to the clinical educators shifting the emphasis to a facilitative approach, using questioning as a key strategy to support individualised student learning.

Nevertheless, this changing practice became a learning challenge for the clinical educators; as a child who is learning to walk also finds that the learning process is challenging. The idea of learning the basic skills and finding key elements of the model may have assisted them to come to terms with what the change meant for their practice. This did not occur for all educators in the same way or at the same time. To be more specific, two of the clinical educators recognized the benefits of the shifting role to one as a facilitator at the beginning of the study, three educators developed this recognition during the study, and one continued to build resistance against the model even after the clinical placement was completed. In the quotes below, two clinical educators describe different feeling towards their changing practice in the CRP model.

> *For me, I like it* [being a facilitator]. *I don't have to explain many things. I ask the questions.* (Ayu-CE)
>
> *Previously, we focused on patient case. What is the patient-case? How is the patient-case? The nursing care? Reflective practice lessen that…*(Gadis-CE)

In her quote, Ayu described her positive feeling towards the CRP model. In contrast, Gadis demonstrated her potential concern that the CRP model was diminishing the focus on patient care as she said *Reflective practice lessen that*. The reason for this variation and perceived difficulty might be because as facilitators they were expected to be more actively engaged with the students during the supervision process. Reflecting on my experiences as a clinical educator, this shift can be a challenging process for the clinical educator as it is easier to ask the student to recall facts related to their clinical outcomes rather than assisting the students develop their critical thinking ability using a more exploratory approach. In contrast, when the clinical educators acted as a facilitator, they had to think and prepare themselves with questioning strategies to facilitate students' ability to critically think or to explore what learning issues were occurring for the students.

The shared experiences that occurred during the CRP model implementation highlighted the learning process of the clinical educators and student nurses when changing practice occurred as an outcome of the CRP model. In particular, the changing practice was about a shift in the clinical educators' role from a supervisor/assessor to a facilitator. Despite the challenges faced by the clinical educators as they changed their student supervision practice, both clinical educators and students acknowledged that the students obtained a more positive learning experience as an outcome of using the CRP model. The more positive outcomes were obtained due to the changing practice that created a more relaxed and safe place for the students to explore and to learn.

7.3 **Finding your feet**

As a result of increasing identification of the CRP model's benefits on student learning, both the clinical educators and student nurses accepted and became familiar with the reflective activities provided in the model. *Finding your feet* describes how someone becomes familiar with their current situation or experiences, in this case the use of reflective approaches to enhance student learning during their clinical placement. *Finding your feet* became important in the CRP study as it highlights the sharing of experiences between the clinical educator and the student nurse. Interestingly, both clinical educators and student nurses moved at a different pace. In general, it appeared easier for the students to find their feet while the clinical educators struggled at times. This section outlines the shared experiences between the clinical educators and the students in finding their feet.

For the students, the process of finding their feet started when they became aware of the positive benefits they could obtain from reflective activities in the CRP model. This is when they started to engage with the CRP model and develop self-awareness of their own practice. Both the clinical educators and students shared examples of students' learning process after the students' self-awareness increased.

> *...after that the student reflected on what and how* [her experience in giving colostomy care]*, so she could evaluate herself.* [The student said] *"I found out that my weakness were on bla bla bla" So, when the student is aware of herself, next time she has an effort* [to improve it]*, or at least she knows about it.* (Ayu-CE)

> *I have got something different with what I had before. With reflection, when I saw something, I asked myself: Why did it happen? How could it be like that? Previously, I only followed routine activities in the ward, but now each time I see, I ask why this and why that.* (Janet-SN)

The clinical educator highlighted that the student's awareness may lead to improved future actions. While the student emphasized that her awareness assisted her to think

critically about her routine activities in the clinical practice setting. Another student mentions her conscious engagement with her clinical practice activities:

> *I become more careful in doing something to the patient, because my brain always think whether I did the right thing or not.* (Emily-SN)

In her quote Emily illustrates her growing practice competence as she is able to critically reflect creating a continuous learning process. Quotes from the clinical educators and students highlighted the development of the student's self-awareness as an outcome of their involvement in the CRP study with students finding their feet during the second clinical placement.

The clinical educator's self-awareness also increased in the second AR cycle. This might be best described as the clinical educators being in the process of finding their feet. In the following quotes from a clinical educator and student; the clinical educator's self-awareness and efforts to implement and use the CRP model are demonstrated:

> *From my side, it was heavy, I actually perhaps an impatient person. If student has to explain this, then I did this and actually I should let the students to tell the story. Later there would be my part to ask.* (Maharani-CE)

> *Hmm I think in the second placement, the clinical educators have tried to match the supervision approach with our reflection. They kept asking about it.* (Emily-SN)

The quote from Maharani demonstrates that it was not so easy to find her feet, however as she became more aware of her behaviour (impatience) how that may influence the student's ability to reflect, she was able to hold herself back from wanting to interject and let the students share their stories. Emily's quote highlights that the clinical educators were aware of the need to seek feedback on the process as *they kept asking about it*. Nevertheless, one of the clinical educators in particular was really struggling to accept the CRP model and she seemed to never find her feet in

the CRP study. Her resistance to the CRP model was expressed through these quotes:

> *It was out of what we expect from the students.* (Gadis-CE)

> *...reflection was something really different with our target…* (Gadis-CE)

These quotes highlight Gadis's feelings toward the CRP model. She continued to struggle or resist the changed way of working (*out of what we expect*), it did not fit with what she saw was important (*different with our target*) and possibly was related to the potential loss of power she was experiencing as an outcome of the CRP model.

Another meaning of *finding your feet* is gaining confidence after experiencing something new or novel. Students felt confident with their nursing practice following the implementation of the CRP model.

> *Because this reflective report assignment can increase the confidence. I felt confident. My knowledge was increased. More knowledgeable.* (Elaine-SN)

Elaine identified that the reflective activities in the CRP model not only assisted her to increase her confidence, it also resulted in increasing her knowledge. The increasing confidence is more likely due to the students became more familiar with the reflective activities. In regards to Indonesian cultural characteristics, the familiarity issue is related to strong uncertainty avoidance. When someone is familiar with a situation then the level of insecurity due to uncertainty is likely to decrease. In contrast, a clinical educator revealed different feelings.

> *I did not find any difficulties* [in the model]. *I just wonder whether it was wrong or right…actually there was a guideline provided, it was good. However, perhaps hmm…it was not become a habit for me. So I felt not steady yet* [with the model]…(Tiara-CE)

Tiara provides a thoughtful insight highlighting her own reflection about the CRP model. She emphasized that her uncertainty might be due to the unfamiliarity with the CRP model. However, she identified the value of the guidelines provided. Tiara

through her statement that *it was not become a habit for me,* thoughtfully acknowledges that she needed to continue to actively engage with the model in order for her to build her own confidence, to become *steady* in using the model to find her feet. This statement was in part countered as a student commented about the clinical educator approach as:

> *So far, Ms. Tiara and Ms. Putri supervised us very well, particularly Ms. Tiara. She gave us direction if we were confused. She told us to search this and this…She gave us a solution.* (Jessica-SN)

Jessica's quote demonstrated that the clinical educator Ms Tiara was perhaps unaware that the supervision she provided was valued by the students. The students recognised that a structure was provided that enabled skills development to manage their confusion about clinical situations and increase their learning, demonstrating the clinical educators' use of support and guidance when students are unclear.

Reflection is beneficial in this situation as it increases the clinical educator's self-awareness to identify positive aspects in themselves that may lead to higher levels of satisfaction and better practice outcomes as a clinical educator. Essentially, the familiarity of the CRP model assisted in minimizing strong uncertainty avoidance. Most of the clinical educators had incorporated the CRP model approach into their supervision practices. This was not always an easy transition as reflected in the comments of the clinical educators in this and the previous findings chapters. When a student is familiar with the clinical model, it is more likely that their clinical experience will be enhanced. In brief, *finding your feet* demonstrated the interrelated experience of both the clinical educators and students. The clinical educators highlighted an increase in the students' self-awareness and to some degree their own self-awareness. While, the students emphasized their emerging self-awareness that led to an increased self-confidence.

7.4 Taking a stand

Indonesian cultural characteristics are likely to influence the implementation of reflective practice in Indonesia. The CRP model was developed to recognise and where possible assist in addressing those cultural influences that may impede the implementation of reflective practice. Three cultural dimensions that have been considered in the CRP model were high power distance, collectivism and strong uncertainty avoidance. During implementation of the CRP model, the most obvious changes occurring for the clinical educators and the students were related to high power distance. The CRP model assisted in reducing the high power distance between the clinical educators and the students resulting in students having the courage to speak up about their learning needs and processes. For this reason, a theme of *taking a stand* is used. This theme describes a situation when someone has the ability to express an opinion. In the CRP study, the students were able to express their opinions as part of the learning process they were using. This resulted in a change in the culture beginning to occur which related to a change in high power distance.

A clear example is when a student expressed her opinion and challenged a doctor in the clinical practice setting, who as a general rule would not be questioned about clinical matters.

> *In communication, it seems that I had a courage to say* [something]*, even in the second placement, I tried to communicate with the doctor. It was a special achievement for me*...(Melanie-SN)

Melanie mentions that the courage she had to communicate with the doctor *was a special achievement* due to the doctor's position in the clinical setting which is regarded as more powerful and respected than the student nurse's position. This provides evidence that the students were shifting from their previous passive behaviour as noted during the discussions with the clinical educators and others to taking a more active role in discussions post implementation of the CRP model. A

further example of speaking up was provided by Sophie who challenged a ward nurse in the clinical practice setting.

> *If the SOP* [Standard Operating Procedure] *is like this and she* [a nurse] *did it like that, I scolded her. I told her something* [related to the SOP]. *If she found it offended, at least I told her something right according to the literature. I didn't care whether she agreed with me or not.* (Sophie-SN)

Sophie shared her story when she discovered that a ward nurse gave nursing care that was not compliant with the standard provided in ward. In this case, she had the courage to speak up using the knowledge she had gained to interact with and challenge others who maybe in a more senior role.

As mentioned earlier in this section the students' courage is related to decreasing high power distance following the implementation of the CRP model. The clinical educators expressed this cultural change during the reflection session; as they acknowledged some situations where:

> [A student said] "*But mam, I found something different from what I have read." So, the student did not only accept what I have said.* (Sekar-CE)

Sekar described the student's response during the discussion; with the student actively expressing that she had different information and did not agree with the clinical educator. This is a real shift from the characteristic of the students in the previous clinical placement (batch) before the CRP study started, where they were less active in the clinical practice as highlighted here by Maharani.

> ...[The students in the previous batch] *tended to be passive. They listened, answered*...(Maharani-CE)

Accordingly, the clinical educators described the relationship with the students as:

> *From my perception, they* [the students] *are more yeah. we can say parallel, yes we are equal.* (Putri-CE)

I think they are more hmm equal. This means that they were more courageous to bring about the topic in an active position. (Maharani -CE)

Both these clinical educators agreed that the relationship they had with the students during the CRP model implementation had become more equal. This finding highlights that Indonesian culture, particularly high power distance, has been influenced by the CRP model. The theme of *taking a stand* clearly represents a situation where the students were able to and had the courage to provide a response to someone who was usually in a higher position than they were in the clinical practice setting. For the students, the creation of this more equal position was achieved predominantly as an outcome of their increased knowledge in the clinical setting, the use of reflection and the ways in which their learning needs informed how the clinical educators supported them in the clinical setting. The students had begun challenging the clinical educators' and other health professionals' knowledge on routine practices in the clinical practice setting.

7.5 **Summary**

A strong connection has been demonstrated between what has been experienced by all but one clinical educators and the student nurses after the implementation of the revised CRP model. The journey of the clinical educators and the students during the second clinical placement was strengthened by the CRP model from *learning to walk*, then *finding their feet*, and finally *taking a stand*.

The first connection was related to a learning process experienced by both clinical educators and student nurses, as *learning to walk*, resulting in their ability to highlight the elements of the CRP model. They had identified the basic element of the model as enabling them to improve their learning and educational and clinical practice. Following that, there was an emerging self-awareness and confidence within the students as they became familiar with the CRP model that described they were *finding their feet* due to their engagement in reflective activities that facilitated their ability to critically think. The clinical educators and student nurses, then, agreed

that the culture had started to change as an outcome of the implementation of the CRP model. This changing culture was related to a reduction in the high power distance with a more equal relationship between the clinical educators and student nurses developing. This situation assisted students to speak up and voice their learning needs, learning process and the knowledge they had gained during clinical placement, as they finally *taking a stand* in their clinical practice.

In the next chapter, issues related to the students' learning process and the shift of the clinical educators' role are discussed in more detail. In addition, issues about the research process will also be presented.

Hubungan yang kuat jelas terlihat antara apa yang dialami oleh semua pembimbing klinik (kecuali satu pembimbing klinik yang mengalami hal yang berbeda) dan mahasiswa keperawatan setelah implementasi model PiKiR yang telah direvisi. Hubungan pertama terkait dengan proses pembelajaran yang dialami oleh pembimbing klinik dan mahasiswa keperawatan, yang berakibat pada kemampuan mereka mengidentifikasi elemen utama dalam model PiKiR yang membantu memperbaiki proses pembelajaran dan praktik klinik mereka. Setelah itu, kesadaran diri dan rasa percaya diri mereka juga meningkat setelah mereka terbiasa dengan model PiKiR dan terlibat dalam aktifitas reflektif yang memfasilitasi mereka untuk berpikir kritis. Pembimbing klinik dan mahasiswa keperawatan setuju bahwa budaya mulai berubah sebagai akibat dari berkurangnya high power distance dengan terciptanya hubungan yang sejajar antara pembimbing klinik dan mahasiswa. Kondisi ini membantu mahasiswa untuk berani berbicara dan menyuarakan kebutuhan belajarnya, proses belajarnya, dan pengetahun yang mereka dapatkan selama praktik klinik.

8 Discussion

8.1 Introduction

This study aimed to develop, implement and revise a Clinical Reflective Practice (CRP) model to an Indonesian nursing education institution. The CRP model was developed based on the concept of reflective practice and taking into account Indonesian cultural characteristics of high power distance, collectivist, and strong uncertainty avoidance. In addition the study aimed to developthe clinical educators' and student nurses' insight through reflection. To achieve all aims, an action research (AR) approach was used as AR offered an appropriate approach to explore and introduce reflective practice within an Indonesian context that described by clinical educators and student nurses who participated in the AR process in developing, implementing and evaluating the CRP model.

The outcome of this study demonstrated that the CRP model had a positive impact on the students' learning process with the data indicating changes in the behaviour of the clinical educators and student nurses. In this chapter, three issues related to these findings will be discussed in detail. The issues are the richness of students' learning through the changing of culture, changes in clinical educators' role, and engagement with participants. To conclude this chapter, the strengths and limitations of the CRP study are outlined.

8.2 The Richness of Students' Learning through Culture Changing

Reflective activities were aimed at improving the students' learning process during the clinical practice period. The students were encouraged and enabled to determine their own learning needs. Consequently, the students were more in control of their

learning during their clinical placement, resulting in them gaining increased knowledge and confidence as learners. This clinical learning moved from being directed by the clinical educator to student-centred learning approach, where students took an important role in driving their learning process. The students provided many examples of directing their own learning by seeking out new information and challenging existing knowledge. For example, in discussion sessions that took place during the CRP study, the students decided which topics were to be discussed base on their learning needs. This mirrors findings from previous studies which also found that reflective activities facilitate student-centred learning (Joyce-McCoach et al. 2013; Rees 2013). In their study, Joyce-McCoach et al. (2013) used discussion to facilitate Chinese students in reflection and to provide collective constructive feedback from peers. Reflection assisted the students in the CRP study to gain an increased understanding of their learning needs; and therefore their confidence as learners increased.

Furthermore, the students in the CRP study highlighted that the knowledge they gained from the reflection process increased their confidence in practice, including having the courage to speak up about their needs and concerns, and being able to share their new knowledge with other students and clinical educators. Johns (1999) uses a metaphor of 'growth of voice' to describe students' changes relating to the ability to speak up when using reflective practice. Students in the CRP study were voicing their feelings and their own learning needs, as well as having the courage to communicate with other health professionals such as doctors. Glaze (2001) and Paget (2001) emphasize that students become more assertive after they use reflection in their practice. In the CRP study, the assertiveness emerges due to the feelings of confidence they have following reflection process used to explore their nursing practice. This was evidenced as a student mentioned *I told them, the in-charge nurse and the doctor…I had the courage since I got the information* (Grace-SN). As the students increased their knowledge related to their practice and became more confident, their relationship with others including the doctors moved from a passive subservient role to become more like a clinical practice partnership (Wilson, McCormack & Ives 2006).

Correspondingly, most of the students in the CRP study progressed well and were more out spoken and confident when interacting with their supervisors during the clinical placement period. These behaviour changes provide evidence that the introduction of CRP model to these Indonesian student nurses assisted them in surmounting cultural barriers related to high power distance, collectivist, and strong uncertainty behaviour (as described in Chapter One) which they had experienced prior to the CRP study.

Three cultural dimensions potentially impact on cross cultural knowledge sharing (Li 2009) and therefore are considered as having influence on the implementation of reflective practice in Eastern countries (Wanda, Wilson & Fowler 2014). The findings of the CRP study revealed that these culture dimensions were diminished by reflective activities provided in the CRP model. These three cultural dimensions of high power distance, collectivist and strong uncertainty avoidance will be discussed in detail to describe students' development following the implementation of the CRP model. It is important to note that the description of each culture dimension in the next sections will be more focused on Eastern cultures even though some of the cultural descriptions may also be reflected in Western cultures.

8.2.1 **High power distance**

Power distance refers to the degree of inequality accepted in a society (Hofstede 2011). In a low power distance society, people expect that power is shared equally among the member of the society. For example, in most western countries teachers and students have positions in the classroom that are potentially more equal. Students are regularly encouraged to challenge information and do not readily accept all the information given by their teachers. Whereas, when a society accepts unequal power distribution in the society, (e.g. in most Eastern countries), a teacher has the power to determine what and how the students will learn due to them having a higher position than a student. The unequal power distribution is caused by different positions, status or education (Erden 2013).

In the CRP study, high power distance was noticeable during the supervision process in the first cycle of this study. The clinical educators led the learning process for the students and decided what needed to be learnt. Ruth-Sahd (2003) asserts that the power gap between an educator and the students may hinder the implementation of reflective practice and educators should avoid determining what reflection topics the student should have. Interestingly, one of the clinical educators in the CRP study mentioned that *it would be better if we direct the reflective activities for the students* (Gadis-CE). This statement demonstrated a reluctance by this clinical educator to use the CRP model by maintaining the high power distance and failing to accept that students were able and capable of making decisions about their own learning need. This reluctant behaviour of the teachers who live in a high power distance society (such as Indonesia) is likely to occur due to difficulty in accepting a student who examines their practice (Minnis 1999). This potentially explains the reluctance of some clinical educators to engage in the CRP study as they may not be ready to experience these uncomfortable and challenging situations where the student asks about or discusses issues or situations that may expose the clinical educators' lack of knowledge, or challenges their knowledge during discussions with a student.

In a high power distance society as in Indonesia, the members of the society are receptive and accustomed to uneven distribution of power (Fock et al. 2012). The employee or the subordinate might be hesitant to take action, question or give input to the employer (Hofstede, Hofstede & Minkov 2010). Indeed, opinions expressed by subordinates may be perceived as a form of challenge to a superior's thoughts (Varela & Premeaux 2008). In a clinical situation, nursing staff may find it difficult to express their opinion or provide input to the nurse manager as this may be regarded as a confrontational act. In the nursing education settings, the students are reluctant to initiate an action in the learning process and this results in submissive behaviour as an outcome of uneven power distribution between the educators and the students.

Findings of this current study demonstrated that high power distance was reduced after the model had been implemented for several weeks. Almost all the clinical educators and the student nurses acknowledged that this resulted in a more equal

position in their relationship. Consequently, the students had gained courage in voicing their feelings and learning needs. The CRP model was credited with facilitating their increasing self-awareness and confidence. The students and some educators identified these benefits of reflection as enabling the students' assertiveness in their clinical placement period.

There are some possible reasons for the progress of students' development as a result of decreased high power distance in this CRP study, for instance the students were more knowledgeable and the culture of learning within the clinical environment was changed. Firstly, students are more knowledgeable in terms of increasing clinical practice knowledge due to the requirement to search the literature for evidence to support their reflective report assignment. When the students have increased knowledge, they are more confident in responding to the clinical educators' questions. Gaining skills in searching the literature, finding and applying the evidence related to clinical practice has the ability to foster self-awareness as well as assisting in illuminating and assisting in resolving difficulties found in the clinical practice setting (Glaze 2001). Crucially, this ability to search and assess the literature also has an outcome for nurses of providing the foundation skills to be life-long learners.

The second reason for the decreasing high power distance in the CRP study is the changing environment in the clinical practice setting, particularly the changing behaviour of the clinical educator within the environment. The clinical educator's role changed from a supervisor/assessor to a facilitator (this issue will be discussed in the next section). The student nurses acknowledged that the clinical educators changed the way they asked questions during the supervision period. Indeed, students were able to compare their clinical experiences including the supervision process before and after the CRP model was implemented. This changing behaviour created a more comfortable situation for the students in the clinical practice setting. A safe environment is needed to foster students' reflective development (Horton-Deutsch & Sherwood 2008) and students' learning in general (Delany & Watkin 2009). A safe learning environment refers to a learning situation where students do not feel like they are being assessed or judged on their knowledge by the clinical

educators (Delany & Watkin 2009), as described by a student in the CRP study as *the clinical educator really want to know our progress, not to evaluate it as before* (Jackie-SN). As a result, students felt less-pressure as they moved away from being assessed by the educator to facilitated discussions resulting in them having increased their engagement in the learning process during the second clinical placement period.

In brief, students had more knowledge and the clinical learning environment had changed. This provides an explanation about how the CRP model enabled Indonesian students (as one of the high power distance societies) to be more confident during their clinical placement period. These positive outcomes reduced high power distance application in the students' learning and influenced another cultural dimensions -collectivist.

8.2.2 **Collectivist**

Collectivist refers to how people in a society interpret their relationship between self and others (Li 2009). In a collectivist society such as Indonesia, people focus more on the group's interest than an individual's interest (Hofstede 2011). Group goals are more important and initiatives by the individual are not encouraged (Pizam & Fleischer 2005). If individual initiative is not encouraged this means that reflection or reflective practice is unlikely to exist. In other words, people in a collectivist society are identified as being strongly influenced and motivated by the group's norms (Triandis, McCusker & Hui 1990), with relatively minimal attention given to individual needs and rights (Varela & Premeaux 2008).

Introducing reflective practice, potentially creates a barrier for the practitioner or student nurses since individuals are expected to focus on and be aware of their own needs in reflection (Wanda, Wilson & Fowler 2014). The CRP model assisted student nurses to deal with the resistance to individual initiative and the need to maintain the group's harmony by supporting the students to use reflection to identify and think about their own learning needs and the actions needed to increase their nursing knowledge and skills. The facilitation process became one of the strategies in the CRP study to reduce the collectivist dimension concerns experienced by the

student nurses (Joyce-McCoach et al. 2013). From the observation session, some of the students were reluctant to speak up or offer their thoughts in the beginning of the implementation period; this may have been due to them did not wanting to 'be different' (Kuswandono 2014). During the clinical practice period, students were asked to write a weekly report of their reflections and an exploration of their own experience. In this case, students were exposed to opportunities through the reflective process that supported their increasing awareness of their own learning needs and they gained confidence and capacity as students and nurses.

Interestingly, Turale et al.'s (2009) study also found that exposure to individualist societies who expect individuals to express their thoughts and needs influenced individuals who originally comes from a collectivist society. In their study, Japanese nurses who graduated from Western countries or who were born overseas indicated that limited communication in collectivist society hindered their decision-making process or involvement in critical discussion with others (Turale et al. 2009). This means that the opportunity to be exposed to different cultural characteristic may change individual behaviour. In regard to the CRP study, the Indonesian student nurses (as a part of collectivist society) were exposed to reflective practice that predominately focused on student driven needs. The learning needs were determined and fulfilled by each student as an individual as well as participating in the group reflective discussion.

Another strategy used in the CRP model to minimise the collectivist dimension was group reflective discussion led by various members of the student group. The students' identified learning needs at the time of discussion drove group learning. The students experienced a different learning process in terms of the content and the approach used. In the discussion the students reflected on experiences that were interesting, they were concerned about or found challenging topics. These topics were then agreed on by other group members as interesting and needing to be discussed. This strategy promoted the students' willingness to share their reflections in a less-pressured environment since they were peers (Devita 2000) and they had the same objectives to achieve. A student in the CRP study said *I realised that*

[group discussion] *was effective learning, we can discuss the topic among other students, to reinforce each other* (Irene-SN).

Similarly, Joyce-McCoach et al. (2013) found that a small group discussion assisted Chinese students to reduce the feeling of losing face through collective construction of responses. It is likely that peers in a small group discussion would provide more constructive feedback for the group member as they are all in the 'same shoes'. In contrast, Wen et al. (2015) argued that group reflective activities for Chinese students may not be successful due to their behaviour in avoiding conflict in a group. This raised a contradiction as Wen et al. also agreed that reflective group activities enabled the students to focus on the presented issues. Even though Chinese and Indonesian cultures share similar characteristics of avoiding conflict as an application of collectivism, students in the CRP study were able to, in most instances, comfortably position themselves so they could respectfully challenge or respond to their peers during reflective activities.

This group activity was more powerful than an individual activity since the group members gave each other encouragement and assistance to view their experiences from different perspectives (Platzer, Blake & Ashford 2000). As well as learning from others, having a forum to discuss their experiences made them feel valued and supported (Manning et al. 2009) and fostered awareness of other students' identity and support due to the emerging commonality among the students during the discussion (Laverty 2012). This was used as a way of reducing collectivism for the students in the CRP study. However, it is important to consider that the students need to feel confident with their own practice before group reflection becomes effectively used and they are comfortable with it (Laverty 2012).

8.2.3 **Strong uncertainty avoidance**

The last dimension of culture that contributed to the implementation of the CRP model is strong uncertainty avoidance. Uncertainty avoidance refers to the extent to which uncertainty and ambiguity can be accepted in a society (Hofstede 2011). In a strong uncertainty avoidance society, such as Indonesia, ambiguity is experienced as

a threat of life, therefore it must be overcome (Matusitz & Musambira 2013). People who live in a strong uncertainty avoidance culture avoid unstructured, unclear and unpredictable situations (Merkin 2006). Accordingly, they expect written rules about how to behave or how their society will function (Muratbekova-Touron 2002; Ndubisi et al. 2012).

Having written rules is the chosen mechanism to assist in maintaining the stability of the situation and minimize uncertain events as a result of changes (Pizam & Fleischer 2005). It is common in Indonesian education settings that students expect structured, detailed written clinical practice guidelines. This is due to strong uncertainty avoidance behaviour of student nurses who experience insecure feelings prior to the clinical practice period or when in a new clinical practice setting. In regard to reducing strong uncertainty avoidance in the CRP study, detailed guideline about the model were provided for the clinical educators and the students, including examples of how to write the students' reflections.

However, such written and detailed rules lessen initiative and creativity as people are likely to passively follow the rules. Individuals living in strong uncertainty avoidance societies, can lack the initiative to change (Pizam & Fleischer 2005) and may be afraid of making decision for themselves (Muratbekova-Touron 2002). In contrast, the students in the CRP study were enabled to engage in initiatives related to their clinical practice through the use of a structured reflection template using 5Ds (details can be seen in Chapter Five). Some students highlight that the 5Ds guided their reflection process, which was pivotal in reducing their uncertainty avoidance of the new model. By writing the reflective report as one of the curriculum assignments using a structured template, the students in the CRP study were being 'pushed' to think about their experiences. All students mentioned that they learned many things from the reflective report process.

This finding was different to Jindal-Snape and Holmes' (2009) study where almost all the students complained about the time consumed by reflective journaling and even identified it as a stressful activity. The difference might be because in Jindal-Snape and Holmes's study, the reflective journaling was an added activity to the

curriculum, whereas in the CRP study, all reflective activities were integrated into the curriculum. The students in the CRP study did not complain, as they had to complete all the reflective activities as a curriculum requirement for clinical placement completion. This is another description of high power distance when the students in a submissive role and accept everything decided by the clinical educator.

In fact, reflective reporting was demonstrated as benefiting them in terms of their self-development. Bradbury-Jones et al. (2009) noted that there was a possibility that the students may fabricate the stories in order to fulfil the supervisor's expectation when they read the reflective report. This was acknowledged by a few students in the CRP study during the reflective session in the first AR cycle as they mentioned that the reflection topics they choose depended on how easy it was to access the related literature. In writing their reflective report, the students had to provide theoretical justification related to their reflection. Nevertheless, in the second AR cycle, the students indicated that they were more honest in their approach to reflection since they had gained a greater awareness of their own learning process. This increasing awareness became another indication that the students' confidence and capacity was increasing, and that they were embracing reflective activities as an essential component of their professional practice.

In regards to minimizing the unclear and uncertain situations experienced by students during reflective sessions,in the first cycle they preferred to reflect on technical matters, such as clinical procedures as they are more concrete and structured, although writing reflection about technical matters did not occur for most students in the second clinical placement. Chong (2009) reported that in Malaysia the preferred topics to reflect on were nursing skills and decision-making. Nursing skills and clinical procedures are topics that students may feel a higher degree of certainty with due to the often concrete nature of the information they needed to acquire; resulting in the potential for their insecure feelings being reduced to some extent. This was also found in Torsvik and Hedlund's (2008) study that demonstrated Tanzanian students who belong to a strong uncertainty avoidance society, focused more on clinical procedures compared to Norwegian students, who belong to a weak uncertainty avoidance society which focused more individualised

care and emotional involvement. Taking the findings of the CRP study and other researchers' experiences into account, it is proposed that the students' feelings of insecurity in the second clinical placement were reduced due to the use of 5Ds structured reflection template. By using the structured template, students had knowledge on what to write and this appeared to reduce their anxiety.

Tanzanian students (likewise Indonesian students) may be categorized as low reasoning students who prefer learning process such as sequencing skills or steps (Murphy 2004). Nevertheless, only a few students in the second cycle of the CRP study continued to demonstrate low reasoning skills, most of the students were able to develop and use high reasoning skills. They had changed the way in which they were learning, using reflective practice which involved describing a situation and their active response to the situation, as well as their related-feelings about the situation (Murphy 2004). In other words, the main difference between low and high reasoning students is in their ability to accept a learning process that requires the students to think broadly and critically and not being dependent on a pre-determined learning process. The learning process experienced by the students in the CRP study corresponds to Kolb's experiential learning theory and describes a process of learning that starts with concrete experiences then transforms to abstract conceptualization (Kolb, Boyatzis & Mainemelis 2001).

In brief, the aforementioned findings confirmed that the impact of the three culture dimensions of high power distance, collectivist, and strong power distance on students' learning were overcome following the introduction of the CRP model. The students became more knowledgeable, more confident and they enhanced their communication skills, three outcomes that are regarded as the elements of student empowerment (Hajbaghery & Salsali 2005).

The students' empowerment in the CRP study may be related to the changing role of the clinical educators which will be presented in the following section. Reflective practice creates a safe place for the students to explore, learn from and, if necessary, reconstruct their thoughts about a difficult and complex situation in the clinical practice setting (Lutz et al. 2013). The changes occurred through reflective practice

are potentially long lasting (Paget 2001) providing a foundation for future nursing behaviour.

8.3 Clinical Educators' Role Changes

Nursing is a practice-based profession, and therefore clinical practice becomes the central component of nursing education. Clinical educators play an important role in the clinical practice learning for student nurses due to their responsibility to bridge the academic and practice setting for the students (Gillespie & McFetridge 2006). As a result of the power distance between the clinical educators and students in a high power distance society (such as Indonesia), the role of a clinical educator during students' clinical placement generally is as an evaluator or assessor. This creates a situation where a student focuses more on the evaluation process as they are more likely to be concerned with achieving grades than the learning process (Elcigil & Sarı 2007).

In contrast, a clinical educator using a reflective practice approach to clinical placement is expected to act as a facilitator for the students to enable and encourage them to reflect and learn from their clinical experiences (Trede & Smith 2012). As a facilitator, the clinical educator has to be committed to provide support to the students in the form of feedback and challenging ideas and beliefs (Bulman, Lathlean & Gobbi 2014). Feedback and challenge from the clinical educators facilitates students' ability to explore and understand their own reflective thought processes (Smith & Jack 2005). It is important for clinical educators to be accepting of this role; as those who are less engaged or invested in facilitating students in this way may contribute to the students having a negative perception about reflection and reflective practice (Paget 2001). The following section will provide a discussion about the changes that occurred for the Indonesian clinical educators' role as an outcome of the CRP model; the changes in their practice; and the impact of these changes on influencing the thinking and behaviour of both clinical educators and student nurses.

The clinical educators in the CRP study adopted a new role as a facilitator, rather than the role of supervisor/assessor. This new role was instigated in order to support students in their development of reflective skills and activities in linking theory and practice (Gillespie & McFetridge 2006). As facilitators, the clinical educators were expected to develop and use facilitation skills during the supervision process (Chong 2009). The clinical educators transformed the way they asked questions from an approach that was dominated by information seeking to use an exploratory approach. The aim of this change was to enable a more questioning clinical education style when working with the students. However, making this change was not easy for some of the clinical educators, particularly when it was related to challenging the existing high power distance dimension of their behaviour. This was potentially due to the clinical educators being required to interact with the students in a more relaxed and collaborative manner (Lutz et al. 2013) when they were used to take a higher status position as is expected in a high power distance society.

The clinical educators, who were not prepared for this changing role, experienced feelings of discomfort during the supervision period. For some the implementation of the CRP model caused an obvious tension with the need to change but also their desire to maintain the more comfortable and familiar high power role. One clinical educator did not engage with this change throughout the process, while the other clinical educators began to interact with the model on an on-going basis and their growing confidence increased their ability to facilitate the process. This was evidenced from their comments on the CRP model and its implementation in the reflection session conducted after the second clinical placement was completed. The challenge in changing their role might be due to lack of knowledge or experience about the students' reflection topics (Cronin & Connolly 2007).

Interestingly, students were able to differentiate those clinical educators who used their facilitation skills to enable the successful implementation of the CRP model from those who did not. One student captured this by stating *with the non-reflective clinical educators, we felt like we were required to achieve something* (Ruby-SN). The student highlighted that they felt being pushed to achieve something by the clinical educator who did not use the suggested facilitation techniques during the

supervision process. In contrast, a number of students admitted that they felt less pressure during the supervision period when a clinical educator was able to support their learning to reflect using different questioning techniques.

From the students' perspective, a competent clinical educator is someone who is able to use strategies to trigger students' critical thinking ability (Trede & Smith 2012); in the CRP study this refers to using reflective questioning technique and facilitation skills. Consequently, the students were more likely to improve their problem-solving and clinical decision-making skills as an outcome of the discussions they had during the supervision process (Trede & Smith 2012). The type of discussion promoted for use in the CRP study was to develop a comfortable or non-threatening situation where the clinical educator assists the students to develop their personal and professional skills (Gilbert 2001). Moreover, to be a facilitator supporting reflective practice, the clinical educator also had to experience the use of the reflective process themselves. It is a significant challenge for the clinical educators to facilitate students in reflection when they do not know how to do it or have not used reflection in their prior clinical practice.

Another challenge faced by the clinical educator was their ability to assist the students expressing their practice experiences in words. Leijen et al. (2009) identified a similar finding regarding the difficulties experienced by teachers in teaching reflection including general difficulties, difficulties to describe, difficulties to evaluate experiences and difficulties related to multiple perspectives. From the teachers' perspectives, the students were not focused on detailed information regarding their experiences and this hindered the process of learning from their own practice (Leijen et al. 2009).

A range of different questioning techniques were used in the CRP study that supported the students to reflect on their experiences. Duffy (2009) emphasizes that a clinical educator should have the ability to ask the students challenging questions, in order to draw the experiences to the surface or into words; this becomes a valuable skill for the clinical educators to develop (Duffy 2009). Three out of the six clinical educators provided examples of the questions they used and how these benefited

them in facilitating students during the CRP model implementation. For instance, the clinical educators asked: *What have you obtained so far? What change occurred from our last meeting? What will you do next?* (Putri-CE). The use of exploratory questions during the supervision period demonstrated that the clinical educators had changed their approach to facilitating the students.

Changes in the clinical educators' role affected the students' learning process, not to mention their own practice as clinical educators. This was a challenging situation for the clinical educators during the implementation of the model. Preparation of clinical educators is an essential element when implementing a reflective practice approach (Braine 2009; Cleary et al. 2013). The clinical educators had a session on preparing to use the CRP model and were engaged from the beginning stage of the research process in order to shape the CRP model. However, they were not fully engaged at that time perhaps because they thought this model only focused on the students learning rather than their own development. The next section will discuss the engagement and participation of the clinical educators and student nurses in the study.

8.4 Engagement and Active Participation

The most challenging part of the data collection process was the engagement with participants. In an AR study, participant engagement becomes a central component of the research project in order to enable participants to change and take ownership of the work as required (Jones & Gelling 2013). Similarly, Biskin et al. (2013) claims that the process of participant engagement in an AR study is as important as the outcome of the research itself. Burrows et al. (2012) uses the image of waves as a metaphor to describe the engagement of participants in an AR study; where sometimes the waves merge to form a larger wave, but at other times the waves are separated into small ripples. This metaphor describes how participant engagement in AR study changes at different time during the study period. The AR researcher may expect that there will be a period of time when all participants are engaged and other

times when the participants only provide a small amount of attention to the AR project. This can be reflective of a commonly identified issue in AR studies that participants demonstrate different levels of engagement and commitment at varying times during the research process (Biskin et al. 2013; Bowl, Cooke & Hockings 2008).

The clinical educators' engagement was variable during the implementation of the CRP model even though the head of Paediatric Nursing department was involved as a participant. The assumption was that this involvement would influence others in the group (use of high power distance) however her involvement did not appear to influence other clinical educators' engagement in the CRP study. Of note there was one clinical educator who appeared to be disengaged throughout the implementation of the CRP model in both cycles while others had different levels of engagement. This situation challenged my role as the researcher as the success of engagement strategies depends on the researcher's ability to engage others according to Jones and Gelling (2013). There are a number of possible explanations for this lack of engagement such as the practicality of the research, ownership issues and high workload.

The first factor which may have contributed to the partial or complete disengagement is the practicality of the research (Burrows et al. 2012). In the CRP study, one clinical educator voiced concern that the model would *lessen* the learning process since the students only learned about simple things in their practice. Adding to this, a number of other clinical educators suggested that reflection was not practical enough to be used during the clinical placement period as it lacked clear indicators by which its use by the students could be assessed. This may go some way to explaining why there were variations in engagement throughout this study. For one clinical educator, there was disengagement or more clearly this educator had never been engaged in the first place. This resulted in a lack of the reflective questioning techniques being used as she continued to use the previous model which focused on direct questioning about patient care and where learning was driven from the clinical educator's perspective. According to Bowl, Cooke and Hockings (2008), different roles, perspectives and expectation between the participants of an AR study and the

researcher may contribute to the slowing of the relationship building process; and may lead to a lack of consistency in the AR process or in the implementation of the intervention itself (in this case the CRP model).

The second factor influencing low engagement by some of the clinical educators was the issue of ownership. The clinical educators may have thought that the CRP study did not belong to them and was more the property of me as the lead researcher subsequently reducing their interest in the study (Cronin & Connolly 2007). Jones and Gelling (2013) claim that the ownership of a research project contributes to the engagement of the participants due to their perceived contribution to the planning and conducting stages of the research process. Snoeren, Niessen and Abma (2011) also experienced a challenging situation when the participants in their AR study did not collaborate as they had expected. Learning from this experience, they proposed to form a communicative space where individuals involved in AR might share any issues they experienced including power issues, conflicting values or differences in perception on the research or research related issues (Snoeren, Niessen & Abma 2011).

This communicative space is important as a means of reflecting on the research process in order to achieve the research goal (Snoeren, Niessen & Abma 2011). In the CRP study, the clinical educators were regularly reminded that this research was not only for me, but also for them and the students in order to improve the clinical learning process. Accepting this situation (that the clinical educators' engagement was like a wave) was difficult at times, I sought to 'put myself in their shoes' to try to understand their lack of support. Acknowledgement of the participants' situation and concerns may assist in increasing the researcher's self-awareness to always try to find alternative strategies for engaging the participants (Bowl, Cooke & Hockings 2008).

The alternative strategy used regarding this ownership issue was to give them a space to express their concerns about the CRP model through individual debriefing sessions after the supervision process in the clinical setting with each clinical educator. This strategy created an opportunity to take their perspectives into account

in refining the model and preparing the way for the second AR cycle. The intention was that greater or improved experiences of the CRP model were achieved and clarification provided of their influence and contribution to the CRP model implementation.

The most successful engagement strategy with the clinical educators during the research process was a debriefing session conducted using a one-on-one discussion. The debriefing sessions assisted the clinical educator to reflect on their supervision process, and focus on how they facilitated the development of the students' knowledge and skills during the implementation of the CRP model. In this case, experiential learning occurred for the clinical educators. Two way communication about their performance took place resulting in them finding strategies for the future (Cant & Cooper 2011). The debriefing session relates closely to the second phase of Kolb's experiential learning cycle (Kolb, Boyatzis & Mainemelis 2001) which is reflective observation, whereby the clinical educators were facilitated to reflect on their own practice during the debriefing session. By using these strategies, I was able to support the clinical educators to explore their feelings, perspectives, and experiences in implementing the CRP model; and the development of the recommended reflective supervision skills.

The last factor that influenced the clinical educators' engagement was due to their high workload and the resulting competing demands and limitations. During the data collection in the CRP study, the clinical educators at times complained that they did not have enough time to supervise students in the clinical settings due to the overload of work required by the faculty. This situation was also highlighted in Cronin and Connolly's (2007) who found that the facilitators' role in their study was not implemented as expected due to workload demands. Indeed, this overload issue is commonly found in the education setting (Siriwanij 2002), however it is the clinical educator's responsibility to provide students with adequate support and a conducive environment to learn (Gaberson, Oermann & Shellenbarger 2014). The CRP model may be an answer to this situation when the students are accustomed to reflection activities which assist them in using a self-directed learning process. However, it does not negate the clinical educator's responsibility to ensure students

obtain the best possible learning experiences and outcomes. The clinical educators should prepare the students in the beginning of the clinical placement to ensure that the students have the knowledge and skills to actively participate in reflective practice and reflection (Braine 2009).

Besides debriefing sessions, being an insider in this research study also increased the opportunities to engage with the clinical educators during the CRP study. I had detailed knowledge of the previous clinical placement period and the work demands that were placed on the clinical educators. This understanding assisted in determining how to integrate this CRP model into the curriculum. Subsequently, the clinical educators and I had an agreement on how to align the research objectives and the CRP model to the curriculum requirements.

Despite the challenge of trying to gain the clinical educators' participation, the student nurses were enthusiastic and engaged with this study. I am proposing that the reason for this was the ability to integrate the CRP model with the actual postgraduate nursing program curriculum. The students followed all required processes in the CRP model and as demonstrated within the study data, integrating the activities within the students' learning process can be argued as resulting in better outcomes. This was also recommended by Ip et al. (2012) as students are more likely to conduct reflection during their learning process if the reflective assignment counts as a formal assessment. Successful student engagement during their learning experience is proposed as providing and sustaining a more positive perspectives on their own learning process (Seib, English & Barnard 2011). However, caution needs to be taken to avoid students merely focusing on the assignment and therefore missing the reflective practice opportunity.

Three important issues emerged during the study namely the richness of students' learning process using the CRP model, the changing role of the clinical educators and the engagement and active participation of the clinical educators and the student nurses. Cultural characteristics were influenced by reflective practice activities in the CRP study; power distance between the clinical educators and student nurses was reduced, which had an impact on collectivist and strong uncertainty avoidance. The

consideration and integration of cultural characteristics in developing the model overcame the challenges usually associated with applying reflective practice in Eastern countries.

8.5 Strengths and Limitations of the Study

8.5.1 Strengths

The CRP model is the first reflective practice model integrating reflective practice into the clinical learning process to be developed and implemented in an Indonesian nursing education institution. The development of the model involved the clinical educators, as they were the key people responsible for supporting the students' clinical learning. Crucially the clinical educators were knowledgeable about contextual factors and were able to determine the feasibility of the model and its implementation. The clinical educators were encouraged and most were actively involved in implementing and evaluating the CRP model. As a result most of the clinical educators had begun to integrate the CRP model into their practice, creating the foundation for sustainability. It is anticipated that the model will continue to provide a framework for clinical practice at the FoN UI beyond the study time period.

The success of this study from the student nurses' perspectives was the integration of the CRP model within the curriculum used by the clinical educator to guide the students' clinical placement. The integration provided benefits to the clinical educators, student nurses and myself as the researcher. Each activity during the clinical practice period was in line with the AR study aim. This resulted in no additional tasks or assignments for the students to complete and the clinical educators to assess, thereby reducing burden and addressing time constraints

Data in this CRP study were collected from multiple sources (clinical educators, student nurses and researcher), across different time frames (AR cycle one and two,

and post AR cycle two) to reflect a more comprehensive data set that enabled the CRP study to be monitored on an ongoing basis. This monitoring provided information to review what was working well and what needed to be changed, and to establish the outcomes of the study for multiple stakeholders (students, educators, researcher, and organization). For this reason, multiple data sources ensured the trustworthiness of the CRP study.

The study has increased the potential for the CRP model being disseminated beyond FoN UI as the students themselves are from a wide range of institutions across Indonesia. As clinical educators in their own institutions, they have a position of authority and will have the power to influence how education and learning occurs in their practice areas. All students involved in this study indicated that they will continue to use reflection in their own practice irrespective of where they are working (a clinical or educational setting). The students who implement the CRP model in their own institutions, will translate what they have learned not only into their practice, but into the learning models they will use in the future. In doing so, they will become future facilitators of the CRP model, changing from the role of supervisor/assessor (clinical educator) to a facilitator of learning.

8.5.2 **Limitations**

There were a number of limitations of the CRP study that should be noted. These limitations included: challenges during the change process; contextual factors; and sustainability of the findings. Each limitation will be discussed in the following sections.

The CRP model was developed to assist the implementation of reflective practice for both clinical educators and student nurses. Not all clinical educators had similar viewpoints or concerns about the need for the implementation of the CRP model. As a result, one clinical educator did not consistently engage with the research process. Indeed, it is acknowledged that to change behaviour requires time and patience. Each individual takes a different amount of time and has a different motivation to change

or to maintain the status quo. As a result, the changes within the clinical educators were not as significant as those observed within the student nurses.

Data were collected from an Indonesian nursing education institution and from a Paediatric Nursing Specialist Program. This 'context specific' nature of the study may limit transferability to other settings. However, a detail description of the research process, the CRP model and Indonesian culture characteristics have been provided. This might be valuable for other institutions with similar characteristics in applying the CRP model. The introduction of the new clinical model in a highly regarded and the largest nursing education institution may also influence other nursing education institutions in Indonesia in considering its implementation within their institutions. Furthermore, the description of cultural characteristics and how they were addressed may assist other Eastern countries to think about how they might implement reflective practice in their education institutions.

Sustainability of the findings could not be gauged due to the inherent timeframe as the CRP study was part of my PhD study, however it would be appropriate in such a study to conduct a follow-up study with the clinical educators and students to identify if the changes were sustained, and if indeed the students and the clinical educators were continuing to use reflection in their practice.

9 An Insider Researcher's Reflection

9.1 Introduction

When I decided that Action Research was the most appropriate approach to achieve the aim of the CRP study, I was confident as I had some prior experiences of working with an action research team. This prior knowledge included what AR is and how to conduct it. However, the more I read articles or textbooks about AR, the more I realized that my previous AR involvement had not provided a comprehensive experience of AR. Some of the key points necessary in an AR study such as active participation from the participants (Harvey 2013) or using reflection to improve the situation (Costello 2011) were not evident in this earlier work. Feelings of uncertainty were created within me prior to the data collection period commencing. Concerns had been triggered about whether I could engage with the participants, obtain enough data or indeed facilitate the change required.

To deal with these concerns during the AR study, I continuously reflected on the process of undertaking the AR as part of my learning journey. I undertook regular unstructured reflection on the process of AR to deal with issues that emerged during the study. These reflections were documented in a journal and are used as data in order to highlight my experiences as a researcher during this study. A thematic review of my reflective entries revealed that there were four main issues identified: the learning process of a novice action researcher; experiences of an insider researcher; engagement with the clinical educators; and relationship with the students. Images and reflection notes from my journal will be used to assist in describing each of the key issues. To end this chapter I have used the 5Ds reflective model to consider the overall study findings and to outline what I aim to do in the future to support translation of findings from this study into practice and to promote reflective practice within Indonesian nursing education.

9.2 The Learning Process of a Novice Action Researcher

Prior to the data collection process, I developed my confidence by listing some positive aspects I had to start the process, such as my existing knowledge about the clinical educators and the students, the knowledge I had about the research setting, and that I had enough knowledge and resources about AR. Generally, having knowledge of a specific situation is identified as an important element for increasing confidence (Hall, Ariss & Todorov 2007). This confidence also assisted in reducing the strong uncertainty avoidance feelings in myself which were related to the new experiences I was to be engaged in.

One of my first learning processes was based on a critique from other scholars about AR design, which is that AR focuses only on a specific topic, and can therefore be viewed as narrow (Costello 2011). Instead of looking at this critique as a criticism I used it as a positive motivation for myself in conducting this study. The benefit I gained was related to recognising that I could focus my attention on the students' learning process, in order to explore and develop useful strategies to enable improvements in the students' clinical learning experiences. The image below can be used as a metaphor to describe the benefit I received from focusing on the specific area.

Figure 28. The image of a rose

(Source: http://pdxretro.com/wp-content/uploads/2013/06/red-rose.jpg)

This image shows a rose in very close view. By looking very closely at the rose, it can be seen more clearly and in greater detail. For example, how many petals does the rose have? Similarly, I could examine learning in detail related to each of the elements of the students' learning such as the influence of the clinical educators, the students themselves, the clinical environment, and the types of questions being asked to promote student learning. The criticism of AR being too specific did not negatively influence me in conducting the study, instead it enabled me to become more sensitive to any reaction or responses from the participants involved in the CRP study. This may have been due to the reflective activities that assisted me in increasing my ability to think critically in response to many of the situations occurring during the implementation of the study. I was able to see and accept that the change occurred differently for the clinical educators and for student nurses; and even within the groups in that occurred at different times. This awareness assisted in determining the next action or strategy to use in the CRP model, for instance student-led group discussion; thereby increasing my confidence in taking action to deal with issues as they were arising.

An interesting secondary effect was that I started to reflect on my own practice as a clinical educator while observing the clinical educators working with the student nurses. Reflection notes on my practice or on the overall research process were documented in the researcher diary as described in Chapter Three. At times I learnt or became aware of something that I had never thought about before, such as the impact of using different types of questions to check on the students' well-being as highlighted in this excerpt from my reflection notes.

Today I observed a supervision process in the ward. There was one clinical educator and five students. The clinical educator used reflective questions that I provided in the Research News Update a week ago. During the supervision process, one of the students cried when telling her story about the patient. I had never seen this situation where a student cried during a supervision process. I think this was because in this CRP model, the students were 'allowed' to share their feelings in the reflective reports, not in the previous model where it focused only on the patients' story. (Reflection notes: 17/04/14)

During the observation on that day, it was pleasing to see the clinical educator's effort to use reflective questions that had been provided for them to assist the reflective process. Surprisingly, a student expressed her feelings facilitated by the clinical educator using reflection. At that time, the clinical educator asked more facilitative questions to assist the student become aware of her feelings and comforted the student by indicating that what she had experienced was quite similar to other student experiences. In Indonesia, where the concept of collectivist and strong uncertainty avoidance applies, the similarity of experiences between one person to another may create be comforting.

This situation also underlined that the right questions used in the supervision process can enable students to reflect on their experiences, particularly for something that the student themselves have identified as being really important to them. When observing the clinical educators using reflective questioning techniques, I could see that the students were gaining positive experiences from these reflective activities. This AR characteristic of focusing on a specific topic assisted me in facilitating changes in the participants. The more practice was explored (*focus on the specific topic*) following the implementation of the CRP study, the more I learnt and gained skills such as increasing my critical thinking and reflection skills. I now have more knowledge about my own practice as a clinical educator and have changed my perspective about myself through reflection on and learning from the clinical educators' experiences and their interactions with students that I observed during the CRP study.

After I observed Maharani today, I am aware that some of my strategies I used in the supervision process could be enhanced by applying Maharani's strategies which was to facilitate the students' learning while they did something to the patient. This strategy was really helping the students to apply the knowledge they obtained in the classroom. I can see the difference now when I compare observations which I conducted today and yesterday. (Reflection notes: 06/11/13)

In this excerpt, I reflected on my practice as a clinical educator while doing observations on two clinical educators. Different strategies used by the clinical

educators created a different learning process for the students; I learnt some successful strategies and identified strategies to be avoided. Evidently, AR enabled me as the researcher to also learn during the research process as in most AR in the education discipline, teachers as the researchers develop themselves during the research process (Phillips & Carr 2015).

9.3 The Experiences of an Insider Researcher

Prior to the data collection process, I prepared myself for a new role as an insider researcher. I was confident starting this AR study in a setting that I have known before and was quite familiar with in terms of the people and the environment. However, these positive feelings did not help during my first contact with the clinical educators.

I was nervous before the meeting being held. This feeling was because my new role as a researcher among my colleagues, people whom I know well and who know me well. I was afraid that I would be judged for what I will do regarding my research. I also had a feeling that they might not take this research seriously or they will rely on me to do everything related to this research, which is not matched with this research approach – action research. (Reflection notes: 25/07/13)

These nervous feelings I had prior to the first meeting could be an example of stronger uncertainty avoidance dimension; an anxiety feeling that arises when someone has to face a new situation. Generally, during an anxiety situation, all negative thoughts come up. In my situation, three negative thoughts emerged, would I *be judged for what I will do*?; *they might not take this research seriously;* and would the clinical educators be reluctant to participate which *is not matched with this research approach.* Even though not all negative thoughts occurred, the concern that I had about the participation of the clinical educators became real when they said that they trusted me to finalise the model and the syllabus for the integration of the CRP model for the students' clinical placement.

Some clinical educators said that they believe in me to develop the model. They will agree and follow all instructions from the researcher. This is the situation of being an insider researcher where the participants count on the researcher who they knew previously; and therefore they ask the researcher who knows everything about the participants and the setting to finish the work. However, it might also be a sign that the clinical educators did not fully understand action research. I will keep reminding them of the nature of an action research. (Reflection notes: 27/09/13)

In order to overcome this, my previous knowledge about the characteristics of each of the clinical educators was used in deciding to approach the clinical educators individually to encourage them to be involved in refining the CRP model. I believe this approach was successful due to my flexibility in making an appointment to meet with them when they had time to discuss the study as well as the different conversation techniques used with each of them which resulted in their increased ownership of the study. A metaphor of this situation can be described as a puzzle (see Figure 2) where it has many and varied pieces. We then have to think of how to connect each piece to its surroundings. The main idea of how to solve a puzzle is similar to the strategy used to engage with the clinical educators, where I had to find an appropriate way to communicate with different clinical educator. Each clinical educators' characteristics (i.e. puzzle pieces) needed to be considered before engaging with them. From that moment on, an individualised approach was used whenever possible to involve the clinical educators, or the students, during the implementation of the CRP model.

Figure 29. The image of a puzzle

(Source: http://cdn.remember.de/out/pictures//promo/puzzle_komp-2-detail.jpg)

In the methodology chapter, the advantages and disadvantages of an insider researcher were discussed. If I had not been an insider researcher, there were two possibilities that may have occurred in regards to the engagement process with the participants. First, it may have taken a longer time period to engage with the participants since you do not know them. On the other hand, it may take a shorter period, since my position as a researcher may have 'pushed' them to provide a prompt response as in a high power distance society where a researcher is seen as someone who has more power in the relationship. This of course is contradictory to the reflective model I was using which takes into account Indonesian cultural characteristics; therefore it would not be justifiable for me to use the very same characteristics to gain power in this situation.

Another concern as an insider researcher was that I tried to be the same person while doing this insider researcher role. However, I gained a sense from the clinical educators and students that they regarded me as a different person.

I felt the clinical educators treated me differently since I started this research. During an informal discussion about the implementation of the CRP model this afternoon, they acted or responded formally. I still remember their 'normal' response towards me prior to this period. (Reflection notes: 25/10/13)

Whilst the clinical educators were my colleagues, I was now positioned as the researcher and for that reason I was identified as being different. In the beginning I was not comfortable being identified as a different person, however I had to accept the fact that I introduced a new model which might create a different and challenging situation for them as educators. In the next section, further detail will be provided of my reflection on the relationship with the clinical educators.

9.4 Engagement with the Clinical Educators

In AR, participants play an important role during the project. An action researcher usually works with participants by engaging them throughout the research process.

In the CRP study, the engagement with the clinical educators was definitely a challenging issue for me. This perhaps is due to the long relationship I had with them (over 10 years), resulting in having prior knowledge about their personal characteristics. This situation provided a positive feeling in the beginning as I knew who I would be dealing with. However, during the CRP study this relationship was quite different due to my new role as an action researcher and their role as participants. A new form of relationship developed with the clinical educators as I was there to introduce a new clinical practice model for the students. No-one within the group had experienced this kind of relationship before. From my point of view, I was still the same person but with a different role – similar but not the same. Nonetheless, I have to admit that the embedded title of 'the researcher' influenced my relationship with the clinical educators.

I felt uncomfortable because I had to think twice before saying or doing something. I was afraid that I would create uncomfortable feelings and as a result make their participation a must do; not because their willingness to be a better clinical educator. I tried not to be prejudice about their behaviour. It is a bit difficult since I have known them for almost 15 years. (Reflection notes: 03/10/13)

Even though I have been working with them for more than a decade and the fact that I knew them prior to the data collection began, this did not mean that the engagement process became an easier process. Being an insider researcher meant that I had much easier access to the participants; but maintaining their engagement during the implementation of the CRP model was not easy. This engagement issue bothered me perhaps because I had expected more support from them (and perhaps this was an example of collectivism in me). I believed in the aim of the study, to improve the students' learning and therefore this may have provided an impression that they 'had to' contribute to this project. It was therefore important for me to reflect on my thinking and behaviour as we worked together on this CRP study. I was aware of the potential lack of engagement from the beginning of the CRP study when the first session occurred with the clinical educators about the CRP model development and not all of the clinical educators came to the meeting. Even though, the clinical

educators and I had developed the model together not all who had agreed to participate voluntarily in this study contributed in the meeting.

Maybe I expected too much from them. They did show their enthusiasm for this study in the beginning, but now they do not focus on the supervision process. I know that they are so busy with the load from the faculty, but they have to make their time to come to the hospital. I am 'out of the circle' now, so that is why I can see objectively that sometimes we, as the clinical educators, did not place a high priority on the supervision process for students in the clinical setting. (Reflection notes: 12/11/13)

To understand why the clinical educator did not place a high priority on attending to the students' supervision schedule, I reflected on my previous practice as a clinical educator and identified that I had sometimes behaved in the same way and I was feeling guilty because of that. It was noted that during the implementation period of the CRP model, the clinical educators were busy with their workload from the faculty, which reduced their time to supervise the students. I was not sure whether it was a condition of disengagement or they just could not manage their time. In reflecting on their behaviour, my reasoning for their lack of time to supervise students may have been due to their preference for working on other activities that allowed them to stay in the faculty where they felt more comfortable, rather than visiting the clinical setting and conducting supervision for the students. It was a challenge for me when I had to address this issue with them. Providentially, the clinical educators agreed that they must do better in the next semester regarding the supervision schedule, even though in the beginning they tried to use high workload as an excuse for their lack of engagement with the students.

In regard to the response I had towards the engagement issue, I felt that I was like a spider caught in a spider's web.

Figure 30. A spider and its spider's web

(Source:
http://www.animalsandenglish.com/uploads/6/6/0/6/6606397/2614500_orig.jpg)

One characteristic of the spider's web is resilience – the threads are strong so when the wind blows it does not break. If an area of the web is damaged, it is only in that local area. The damage will not affect other areas of the spider's web. I also became resilient, like the spiders web, during the CRP study, particularly with regard to the engagement issue. When the clinical educators' engagement was variable sometimes at a high level and at other times at a low level of engagement, I had to be strong in order to continue the research process; even when one clinical educator consistently did not engage in the research process. I had a belief that her lack of engagement would not affect the other clinical educators' engagement, like the resilient string of the spider web. The belief I had was correct as at the end of the implementation period all clinical educators but one were engaged with the CRP model at various levels; some of them were fully engaged, while the engagement of others was partial and variable.

To deal with the lack of engagement, individualised debriefing sessions were introduced with the clinical educators. The sessions mostly occurred after the supervision period with the students. This strategy was chosen because an individual discussion would support them to express their thoughts in a more private and confidential situation. This strategy prevented the risk of *losing face* with the other clinical educators. The clinical educators also seemed to appreciate these individual

discussion sessions, as described in my reflection notes on one debriefing session with a clinical educator.

This day I observed one of the clinical educators. Following the discussion with the students, she told me that she did not tell the truth about her feeling towards a patient's case. The patient was in a critical condition. The student hoped that the patient could survive. However, in a debriefing session after that, the clinical educator told me that deep in her heart, she hoped that it would be better for the patient to die, in order to avoid a more painful life. She realized that it would not look good in front of the students if she told that to the students. She thanked me because she felt relieved telling me what she felt about the patient's case. At that moment, I realised that reflection was also able to facilitate clinical educators to be aware or realise their own feeling during the supervision process. (Reflection notes: 05/12/13)

The debriefing session with the clinical educator was satisfying as I could feel and see the direct impact of the individual debriefing session. This feeling also emerged as I noticed that the clinical educator had gained something positive from the reflection activity, using this as a way to express her feelings and awareness of her actions. Importantly, I believe that the clinical educators were becoming more aware of their actions by using reflection as part of their practice and were therefore creating a stronger web where their own reflection and practice were becoming strongly interconnected. As this CRP study has demonstrated, reflection does make a difference as it assists in improving their future actions.

9.5 **Relationship with Student Nurses**

Despite the challenges of engaging with the clinical educators, a successful collaboration was established with almost all students in the CRP study from the beginning. This might be because they were more open minded to a new initiative in order to improve their own learning experiences or it may have been due to their submissive behaviour to myself as their prior lecturer (as an application of high

power distance). I had a prior relationship with the students during their master's degree program, as can be seen in Figure 2 (Chapter One) as the pathway of nursing programs in Indonesia, the paediatric nursing specialist students must graduate from a two-year master degree program (majoring in paediatric nursing). During the two year period of their master's degree, the students spend their first year in the classroom, it was during this time that I was one of their lecturers.

The challenge for my relationship with the students in the beginning of the data collection period was related to decreasing the impact of high power distance between myself, as their previous lecturer, and them as the students. From my first contact with the students during the study, clear information was provided about my role as a researcher and that I was not a lecturer or clinical educator. Importantly, I was aware that initially the students may have felt uncomfortable and unable to say no to me as they knew me as *their teacher* as noted in my reflection notes.

One day, when I was observing a clinical educator, three students approached me and asked for my apologies since they could not submit the clinical report on time. They felt ashamed because they could not submit on time, which means that they did not help me as their previous teacher. I felt uncomfortable with this situation, because I assumed that the participation of students in this study had not been voluntary. (Reflection notes: 05/12/13)

At one time during the observations, the students came to me to provide an apology, I felt that they acted like they were my students, and therefore they had to serve me as their lecturer. This is an example of the power distance concept where the students felt that they have to serve or give the best effort to their lecturer even though, it had continually been reinforced that I was not involved in their learning assessment because at that time I was a researcher. For over a year I had not had any contact with them due to being in Australia, and had not expected them to treat me as their lecturer. Whilst I was clear that the relationship between the students and I was a participant-researcher, it was evident at this stage that they were not clear about the relationship. This misunderstanding may have influenced the '*voluntary'* nature of their participation.

One way of differentiating my role with the students was to avoid having discussion with the students about patient cases. These discussions are a key component of the clinical educator's role during the supervision period. The students were informed that my role was to answer all their questions related to reflective practice. The students were also reminded that their confidentiality was guaranteed with all the information obtained in the CRP study. They were able to share any of their comments about the CRP study, even if it was about their clinical educators. This strategy was successful in developing a trusting relationship with the students whereby the students regularly shared with me their concerns, comments and experiences.

This afternoon I had a meeting with some students. This meeting was aimed to explore students' experiences on reflection so far. They told me that they were confused on how to find the reflection topic. I explained the reflection process again to them. One thing that surprised me was their honesty when they told me that they felt disappointed with certain clinical educators whom hardly came to the hospital. Indeed, they criticise a clinical educator that acted like an assessor when she conducted the supervision process. At that time, I thought that they really trust me that I would not say anything to the clinical educator. I plan to discuss about questioning techniques with the clinical educators. (Reflection notes: 11/11/13)

The students' honesty regarding their learning process through reflection was very satisfying for me and marked a change in how they viewed me, moving from student-teacher to participant-researcher. I noticed that their reflection topics in the second cycle were really about their progress, compared to the first AR cycle where the reflection topics were sometimes decided according to the literature that was available to them. This was a sign for me that they were moving away from a technical approach to reflection to a learner driven approach. Indeed, the stories or experiences they shared with me influenced a number of actions undertaken in the CRP study. For instance, during a meeting the students outlined the reflection process used by some educators, the description provided made the process sound like a student assessment. In response a Research News Update was developed outlining different questioning techniques for the lecturer to consider. A discussion

about this topic was held with some of the clinical educators in their debriefing sessions where important matters were raised without naming the students who made the comments or had raised the specific issues. Keeping the promise of confidentiality was crucially important in maintaining the integrity of the CRP study and my role as a researcher. The students' reflections were also used to refine the CRP model before their second clinical placement period started.

A metaphor for this situation is like musicians playing their musical instruments together in an orchestra. All of the musicians are expected to know their own role/part to produce a beautiful song (as seen in image 30). Similarly, in the CRP study, the students and I knew our roles and that they were complementary and this resulted in an outstanding collaboration where we were able to use reflection as a means of learning and changing our practice together creating joint musical play.

Figure 31. A joint musical play

(Source: http://latimesblogs.latimes.com/.a/6a00d8341c630a53ef01538f58370b970b-pi)

5Ds' Reflection

It is appropriate and fitting for me to end the thesis by using the model that was developed in the study for my final reflection. I will use the 5Ds structured reflection template: doubt/differences; disclosure; dissection; discover; and decision to present my reflection on the overall study, consider future actions and outline my final thoughts.

Differences

The CRP model provided different experiences for the clinical educators, the student nurses and myself as a novice action researcher. For the clinical educators these differences were related to changing their clinical education practice, including the need for them to change from an assessor of students to a learning facilitator; this was not always an easy transition. For the student nurses, they were exposed to different clinical learning experiences that supported their growing self-awareness, increased their self-confidence and promoted their ability to think critically. As a novice action researcher, I learned how action research can significantly improve clinical practice in an education setting. Importantly, I identified that differences related to culture were minimised as an outcome of the CRP model. High power distance, collectivism and strong uncertainty avoidance were all minimised and resulted in the students finding a safe place in reflection and the courage to voice their learning needs and at times their emotional needs as nurses.

Disclosure

As a researcher, I have a responsibility to disseminate my findings to a wider audience. The first audiences with whom I will share my findings are my colleagues who come from a range of nursing specialties in FoN UI, as it is anticipated that they will apply the CRP model for their students as an outcome of this study. The graduates (student nurses) involved in the CRP study are anticipated to act as champions for the use of the CRP model when they resume their work as clinical educators and/or specialist paediatric nurses in their own organizations across Indonesia thereby spreading the findings and use of the model further. Dissemination

through conferences and peer reviewed publications nationally and internationally, will provide the opportunity to spread the findings further and to strengthen the model.

Dissection

Reflective practice is a well-known concept that was originally developed in Western countries. Up to this point, many studies have provided the positive benefits students can obtain from participating in reflective practice. However, the development of reflective practice in Eastern countries, including Indonesia, is just beginning. Minimal literature was found related to reflective practice model in Eastern countries; this may due to the influence of Eastern cultural characteristics that can hinder the implementation of reflective practice. Findings from this study underline that a consideration of cultural characteristics prior to developing or implementing reflective practice in Eastern countries is essential to reduce the adverse influences of high power distance, collectivism and strong uncertainty avoidance as the primary culture dimensions of Eastern countries.

The main strategies used in the CRP study were 1) using a structured template (5Ds) for reflection; 2) conducting group reflective discussion, which was led by the students; 3) encouraging the clinical educators to use reflective questioning techniques and to conduct regular supervision processes thereby increasing their interaction with students in the clinical setting.

Discover

The CRP study generated knowledge that demonstrated reflective practice is influential in an educational setting within an Eastern culture, particularly related to the application of high power distance, collectivism and strong uncertainty avoidance. An improved learning process may be created if the influences of these cultural characteristics can be minimized. Subsequently, the CRP model that contains reflective activities may be applied to other students within the FoN UI. Indeed, other Indonesian nursing education institutions, with similar characteristics to FoN UI, may be able to successfully apply the CRP model to support their student

nurses and academics and in so doing they too can discover the benefits of reflective practice for students to enhanced their learning and critical thinking and for clinical educators to continue developing and changing to become facilitators of learning.

This study was valuable in improving Indonesian students' clinical practice experiences, including supporting changes for the clinical educators and the students. The clinical educators changed predominantly in the strategies they used to facilitate students to obtain the most from their clinical practice experience. In regard to the students' perspective, they were able to critically question their own practice, to speak up when unsure and to challenge when practice is not based on evidence.

Decision

Recommendation for future implementation of the model that the clinical educator are provided the opportunity to develop their facilitation skills to support the introduction of reflective practice prior to the model being implemented in other contexts. In order to maintain the use of reflective practice in the students' learning process, I propose two recommendations for the clinical educators. First, the clinical educators should use reflection as a common practice to continually develop and improve themselves as clinical educators. They may be better positioned to teach the students how to use reflection when they themselves have experienced using reflection in their own practice. Second, reflection should be introduced to the students from the beginning stage of their study period. Previous studies have identified that reflection can be used in the classroom or during clinical placement period (ref). Therefore, reflective activities can be integrated into nursing subjects in the classroom before the students start their clinical placement period.

In addition, there are also two recommendations related to participants' engagement in an AR study. First, the researcher should emphasize the shared ownership of the AR study in order to increase the possibility of the participant engaging in the AR. A very clear expectation and role of the participants during an AR study should be provided in the beginning of the research in order to increase the inclusion of the participants in the AR study. Second, a regular meeting with the participants may assist them to participate and reflect on the research process during the study period.

This may highlight (and alleviate) issues emerging in the AR study and help maintain the research process by making required changes as the study progresses.

My final thoughts

The lessons I learned during my journey as a novice action researcher conducting a study in my own institution as an insider researcher was not as easy as I thought. Even though I had knowledge about the clinical educators I was challenged when they did not act as I had expected. The engagement of the clinical educators throughout the stages of the study was one of the most challenging aspects of undertaking the AR. In my next AR study after completing this PhD, I will focus more on various strategies to engage all participants before starting and throughout the study.

I obtained valuable knowledge and skills in reflection. This has assisted me in developing my capacity as an action researcher and as a clinical educator. Reflection will continue to be an important part of my role as a researcher and as a nurse. Modelling this reflective behaviour will enable me to remind my colleagues of the importance of sustaining the use of reflection in their practice, as a way of improving their own practice as well as supporting student learning. They will be encouraged to continue to use the 5Ds structured reflection template developed in this CRP study as this matches the way of thinking of Indonesian people and has been shown to support student reflection and learning.

Crucially, I have also learned about myself, that I still act and apply the Eastern cultural dimensions particularly collectivism and stronger uncertainty avoidance; even though I had been exposed to individualist and weak uncertainty avoidance societies for many years. This AR study has taught me that I need to know when to position myself as ‘an Eastern person’ and when to be ‘a Western person’. From my perspective, being flexible is important in order to gain positive aspects of each

culture; the most important thing is to continue to regularly reflect in order to develop yourself.

Learning is a treasure that will follow its owner everywhere (Chinese Proverbs); however **Learning is not the product of teaching, learning is the product of the activity of learners** (John Holt).

Appendices

Appendix A. Permission letter from Nurse Education Today

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Appendix B. Ethical approval letter from HREC FoN UI

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Kampus UI Depok Telp. (021)78849120, 78849121 Faks. 7864124
Email : humasfik@ui.ac.id Web Site : www.fik.ui.ac.id

ETHICAL CLEARENCE

The Ethical Committee of Nursing Research, Faculty of Nursing, Universitas Indonesia with regards of the protection of human rights and welfare in nursing research, has carefully reviewed the proposal entitled :

The development of a clinical reflective practice model for paediatric nursing specialist student in Indonesia.

Name of researcher : ***Dessie Wanda, SKp, MN***

Name of institution : ***Faculty of Nursing Universitas Indonesia***

And approved the above mentioned proposal.

Jakarta, 24 May 2013

Dean,

Dewi Irawaty, MA, PhD

Chairman,

Dra. Setyowati, M.App.Sc, PhD

Appendix C. Ethical approval letter from HREC UTS

HREC Approval 2013000217

Research.Ethics@uts.edu.au

Tue 2/07/2013 3:46 PM

To:Val.Wilson@uts.edu.au <Val.Wilson@uts.edu.au>; Dessie Wanda <[redacted]>; Research.Ethics@uts.edu.au <Research.Ethics@uts.edu.au>; iec.rio@uts.edu.au <iec.rio@uts.edu.au>; postaward.grants@uts.edu.au <postaward.grants@uts.edu.au>;

Dear Valerie and Dessie

[External Ratification: The Ethical Committee of Nursing Research, Faculty of Nursing, Universitas Indonesia ¿ 2862/H2.F12.D/PDP.04.00/2013 ¿ 15/07/2013 to 31/05/14]

The UTS Human Research Ethics Expedited Review Committee reviewed your application titled, "The Development of a Clinical Reflective Practice Model for Paediatric Nursing Specialist Students in Indonesia", and agreed that the application meets the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that your external ethics approval has been ratified.

Your approval number is UTS HREC REF NO. 2013000217

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.

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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

Appendix D. Information sheet and consent form for clinical educators in English

UNIVERSITY OF TECHNOLOGY SYDNEY

INFORMATION AND INVITATION LETTER

THE DEVELOPMENT OF A CLINICAL REFLECTIVE PRACTICE MODEL FOR PAEDIATRIC NURSING SPECIALIST STUDENTS IN INDONESIA

Dear Clinical Educators,

My name is Dessie Wanda and I am a student at the University of Technology, Sydney. I am conducting a research project for my degree of Doctor of Philosophy.

The research project aims to develop a clinical model based on reflective practice for paediatric nursing specialist students. The model will benefit clinical educators and student nurses during their clinical placement period, particularly in order to facilitate individual professionalism for both clinical educators and student nurses.

This research is an action research project. Therefore, I would welcome your collaboration to participate in developing, implementing, and evaluating the model. Your participation in this research is voluntary. You are under no obligation to participate in this research. You are able to withdraw at any time without giving necessary reason. Your withdrawal from this research will not affect you in any way.

I will protect your identity, if you are willing to participate in this research and if this research is published, I will not use any identity of the participants.

There are very few risks of this research because it has been carefully designed. However, it is possible that you may experience discomfort during the implementation of the reflective practice model since you will be asked to conduct reflective practice activities which you are not used to it. If you are experiencing such discomfort feelings, you are able to contact me to ask any questions, and I will also distribute information about this research regularly.

If you are interested in participating, *I would be glad if you would contact me on [redacted], and I will ask to you sign a consent form to be a participant in this research.

Yours sincerely,

Dessie Wanda
Phone number: [redacted]
Email address: [redacted]

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.

UNIVERSITY OF TECHNOLOGY SYDNEY

CONSENT FORM (for Clinical Educators)

I _____ agree to participate in the research project: *The Development of a Clinical Reflective Practice Model for Paediatric Nursing Specialist Students in Indonesia (the UTS HREC 2013000217)* being conducted by Dessie Wanda (phone number [redacted]) of the University of Technology, Sydney for her degree of Doctor of Philosophy.

I understand that the purpose of this study is to develop, implement, and evaluate a clinical reflective practice model in the Paediatrics Nursing Specialist Program at Faculty of Nursing, Universitas Indonesia.

I understand that I have been asked to participate in this research because the clinical model is develop for paediatric nursing specialist students and that my participation in this research will involve in the development, implementation and evaluation of the model. The implementation of the model will be conducted during the clinical placement in semester one and two. I understand that my involvement in this study will not give any negative and positive consequences to my general performance as a clinical educator.

I am aware that I can contact Dessie Wanda or her supervisors Professor Valerie Wilson and Professor Cathrine Fowler 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.

I agree that Dessie Wanda 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.

Appendix E. Information sheet and consent form for clinical educators in Bahasa Indonesia

UNIVERSITY OF TECHNOLOGY SYDNEY

LEMBAR INFORMASI DAN UNDANGAN PENELITIAN

THE DEVELOPMENT OF A CLINICAL REFLECTIVE PRACTICE MODEL FOR PAEDIATRIC NURSING SPECIALIST STUDENTS IN INDONESIA
(UTS HREC Ref No 2013000217)

Pembimbing Klinik yang saya hormati,

Nama saya adalah Dessie Wanda dan saya adalah mahasiswa program Doctor of Philosophy di University of Technology, Sydney. Saya sedang melakukan penelitian sebagai bagian dari proses pendidikan saya.

Penelitian ini bertujuan untuk mengembangkan sebuah model praktik reflektif bagi mahasiswa spesialis keperawatan anak. Model praktik klinik yang dikembangkan ini akan bermanfaat bagi pembimbing klinik dan mahasiswa spesialis keperawatan anak pada tahap residensi, khususnya dalam pengembangan profesionalitas individu sebagai pembimbing klinik maupun mahasiswa keperawatan.

Desain penelitian yang saya gunakan adalah penelitian aksi. Oleh karena itu, saya mengharapkan Saudara untuk dapat berpartisipasi dalam pengembangan, implementasi, dan evaluasi model praktik reflektif yang dikembangkan ini. Keikutsertaan Saudara dalam penelitian ini adalah sukarela, tidak ada paksaan untuk terlibat dalam penelitian ini. Saudara dapat mengundurkan diri selama proses penelitian ini kapanpun tanpa harus memberikan alasan terhadap pengunduran diri tersebut. Pengunduran diri Saudara tidak akan memberikan dampak negatif dalam bentuk apapun di masa yang akan datang.

Saya akan menjaga kerahasiaan identitas Saudara, apabila Saudara bersedia untuk terlibat dalam penelitian ini. Apabila hasil penelitian ini akan dipublikasikan, maka identitas Saudara sebagai partisipan tidak akan dipublikasikan.

Penelitian ini telah didesain untuk meminimalkan risiko yang dapat timbul pada partisipan penelitian. Risiko ketidaknyamanan yang mungkin muncul adalah karena model praktik klinik yang dikembangkan akan meminta partisipan untuk melakukan refleksi pada setiap tindakan keperawatan yang dilakukan, dimana mungkin partisipan belum terbiasa untuk melakukan refleksi. Berkaitan dengan hal tersebut, Saudara dapat menghubungi saya untuk bertanya hal yang berkaitan dengan penelitian ini, dan saya pun akan memberikan informasi terkait pengembangan penelitian ini secara reguler dalam bentuk *leaflet*.

Saya akan menjaga privacy dan kenyamanan Saudara selama proses penelitian ini berlangsung. Apabila Saudara berminat untuk berpartisipasi dalam penelitian ini, Saudara dapat menghubungi saya di [redacted] dan saya akan meminta Saudara untuk mengisi lembar persetujuan menjadi partisipan penelitian.

Hormat saya,
Dessie Wanda
Email address: [redacted]

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.

UNIVERSITY OF TECHNOLOGY SYDNEY

Surat Pernyataan Kesediaan Menjadi Partisipan (Pembimbing Klinik)

Saya _____ menyatakan bersedia untuk berpartisipasi dalam penelitian dengan judul *The Development of a Clinical Reflective Practice Model for Paediatric Nursing Specialist Students in Indonesia* (UTS HREC Ref No 2013000217) yang dilakukan oleh Dessie Wanda (no. telp. [redacted]) sebagai salah satu persyaratan selama proses pendidikan pada program Doctor of Philosophy di the University of Technology, Sydney.

Saya mengerti bahwa tujuan penelitian ini adalah untuk mengembangkan, mengimplementasikan, dan mengevaluasi model praktik reflektif selama pembelajaran klinik mahasiswa spesialis keperawatan anak di Fakultas Ilmu Keperawatan, Universitas Indonesia.

Saya memahami bahwa saya diminta untuk berpartisipasi dalam penelitian ini dikarenakan model praktik yang dikembangkan ini adalah untuk mahasiswa spesialis keperawatan anak dan saya akan terlibat dalam pengembangan, implementasi, dan evaluasi model tersebut. Implementasi model tersebut akan dilaksanakan selama proses praktik klinik mahasiswa pada semester satu dan dua. Saya mengerti bahwa keterlibatan saya dalam penelitian ini tidak akan memberikan dampak negatif terhadap penampilan klinik saya sehagai pembimbing klinik secara umum.

Saya menyadari bahwa saya dapat menghubungi Dessie Wanda ([redacted]) atau Supervisor peneliti yaitu Professor Valerie Wilson (val.wilson@health.nsw.gov.au) and Professor Cathrine Fowler (Cathrine.Fowler@uts.edu.au) apabila saya ingin bertanya tentang penelitian ini. Saya memahami bahwa saya dapat mengundurkan diri dari penelitian ini kapanpun tanda ada konsekuensi apapun dan saya tidak harus memberikan alasan untuk pengunduran diri tersebut.

Saya menyatakan bahwa Dessie Wanda telah menjawab seluruh pertanyaan saya dengan jelas.

Saya menyatakan bahwa data yang dikumpulkan selama penelitian ini dapat dipublikasikan tanpa ada identifikasi saya di dalamnya.

_____ ___/___/___
Tanda tangan (partisipan)

_____ ___/___/___
Tanda tangan (peneliti)

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.

Appendix F. Information sheet and consent form for student nurses in English

UNIVERSITY OF TECHNOLOGY SYDNEY

INFORMATION AND INVITATION LETTER

THE DEVELOPMENT OF A CLINICAL REFLECTIVE PRACTICE MODEL FOR PAEDIATRIC NURSING SPECIALIST STUDENTS IN INDONESIA

Dear Paediatric Nursing Specialist Students,

My name is Dessie Wanda and I am a student at the University of Technology, Sydney. I am conducting a research project for my degree of Doctor of Philosophy.

The research project aims to develop a clinical model based on reflective practice for paediatric nursing specialist students. The model will benefit clinical educators and student nurses during their clinical placement period, particularly in order to facilitate individual professionalism for both clinical educators and student nurses.

This research is an action research project. Therefore, I would welcome your collaboration to participate in implementing, and evaluating the model. Your participation in this research is voluntary. You are under no obligation to participate in this research. You are able to withdraw at any time without giving necessary reason. Your withdrawal from this research will not affect you in any way.

I will protect your identity, if you are willing to participate in this research and if this research is published, I will not use any identity of the participants.

There are very few risks of this research because it has been carefully designed. However, it is possible that you may experience discomfort during the implementation of the reflective practice model since you will be asked to conduct reflective practice activities which you are not used to it. If you are experiencing such discomfort feelings, you are able to contact me to ask any questions, and I will also distribute information about this research regularly.

If you are interested in participating, *I would be glad if you would contact me on [redacted], and I will ask to you sign a consent form to be a participant in this research.

Yours sincerely,

Dessie Wanda
Phone number: [redacted]
Email address: [redacted]

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.

UNIVERSITY OF TECHNOLOGY SYDNEY

CONSENT FORM (for Student Nurses)

I _____ agree to participate in the research project: *The Development of a Clinical Reflective Practice Model for Paediatric Nursing Specialist Students in Indonesia (the UTS HREC 2013000217)* being conducted by Dessie Wanda (phone number [redacted]) of the University of Technology, Sydney for her degree of Doctor of Philosophy.

I understand that the purpose of this study is to develop, implement, and evaluate a clinical reflective practice model in the Paediatrics Nursing Specialist Program at Faculty of Nursing, Universitas Indonesia.

I understand that I have been asked to participate in this research because the clinical model is develop for paediatric nursing specialist students and that my participation in this research will involve in the implementation and evaluation of the model. The implementation of the model will be conducted during the clinical placement in semester one and two. I understand that my involvement in this study will not give any negative and positive consequences to my final mark in any subjects during the clinical placement period.

I am aware that I can contact Dessie Wanda or her supervisors Professor Valerie Wilson and Professor Cathrine Fowler 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. The decision to withdraw of this study will not affect my final mark of any subject during the clinical placement period.

I agree that Dessie Wanda 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.

Appendix G. Information sheet and consent form for student nurses in Bahasa Indonesia

UNIVERSITY OF TECHNOLOGY SYDNEY

LEMBAR INFORMASI DAN UNDANGAN PENELITIAN

THE DEVELOPMENT OF A CLINICAL REFLECTIVE PRACTICE MODEL FOR PAEDIATRIC NURSING SPECIALIST STUDENTS IN INDONESIA

Mahasiswa Spesialis Keperawatan Anak,

Nama saya adalah Dessie Wanda dan saya adalah mahasiswa program Doctor of Philosophy di University of Technology, Sydney. Saya sedang melakukan penelitian sebagai bagian dari proses pendidikan saya.

Penelitian ini bertujuan untuk mengembangkan sebuah model praktik reflektif bagi mahasiswa spesialis keperawatan anak. Model praktik klinik yang dikembangkan ini akan bermanfaat bagi pembimbing klinik dan mahasiswa spesialis keperawatan anak pada tahap residensi, khususnya dalam pengembangan profesionalitas individu sebagai pembimbing klinik maupun mahasiswa keperawatan.

Desain penelitian yang saya gunakan adalah penelitian aksi. Oleh karena itu, saya mengharapkan Saudara untuk dapat berpartisipasi dalam implementasi, dan evaluasi model praktik reflektif yang dikembangkan ini. Keikutsertaan Saudara dalam penelitian ini adalah sukarela, tidak ada paksaan untuk terlibat dalam penelitian ini. Saudara dapat mengundurkan diri selama proses penelitian ini kapanpun tanpa harus memberikan alasan terhadap pengunduran diri tersebut. Pengunduran diri Saudara tidak akan memberikan dampak negatif dalam bentuk apapun di masa yang akan datang.

Saya akan menjaga kerahasiaan identitas Saudara, apabila Saudara bersedia untuk terlibat dalam penelitian ini. Apabila hasil penelitian ini akan dipublikasikan, maka identitas Saudara sebagai partisipan tidak akan dipublikasikan.

Penelitian ini telah didesain untuk meminimalkan risiko yang dapat timbul pada partisipan penelitian. Risiko ketidaknyamanan yang mungkin muncul adalah karena model praktik klinik yang dikembangkan akan meminta partisipan untuk melakukan refleksi pada setiap tindakan keperawatan yang dilakukan, dimana mungkin partisipan belum terbiasa untuk melakukan refleksi. Berkaitan dengan hal tersebut, Saudara dapat menghubungi saya untuk bertanya hal yang berkaitan dengan penelitian ini, dan saya pun akan memberikan informasi terkait pengembangan penelitian ini secara reguler dalam bentuk *leaflet*.

Saya akan menjaga privacy dan kenyamanan Saudara selama proses penelitian ini berlangsung. Apabila Saudara berminat untuk berpartisipasi dalam penelitian ini, Saudara dapat menghubungi saya di [redacted] dan saya akan meminta Saudara untuk mengisi lembar persetujuan menjadi partisipan penelitian.

Hormat saya,

Dessie Wanda
Email address: [redacted]

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.

Appendix H. Questionnaires for the clinical educators

Demographic Data

1. Initial : _____
2. Year of birth : _____
3. Highest education qualification: _____
4. Supervision experiences in clinical practice: _____ years
5. Frequency of reading articles:
   □ Very seldom □ Seldom □ Sometimes □ Often
6. Frequency of reading text books:
   □ Very seldom □ Seldom □ Sometimes □ Often

Appendix I. Questionnaires for the student nurses

Kuesioner Data Demografi

1. Inisial nama : _____
2. Tahun lahir : _____
3. Tahun lulus S1 : _____
4. Pengalaman praktik klinik sebelum S1:
   □ Tidak ada □ Ada, selama _____ tahun
5. Pengalaman praktik klinik setelah S1:
   □ Tidak ada □ Ada, selama _____ tahun
6. Pengalaman membimbing di lahan praktik:
   □ Tidak ada □ Ada, selama _____ tahun
7. Frekuensi membaca artikel di jurnal keperawatan:
   □ Sangat jarang □ Jarang □ Kadang-kadang □ Sering
8. Frekuensi membaca buku teks keperawatan:
   □ Sangat jarang □ Jarang □ Kadang-kadang □ Sering

Appendix J. Focus-group discussion guidelines.

Focus Group Discussion Guidelines

1. The aim of the Focus Group Discussion (FGD) is to explore issues relating to the implementation of the reflective practice model from clinical educators' and student nurses' perspectives. The information will be used to refine the clinical reflective practice model.

2. Basic rules in the focus group discussion (FGD):
   - Only one person talk at a time.
   - Topics discussed during the FGD are confidential.
   - There is no right or wrong answer, therefore it is important to share the ideas, experiences, and opinion.

3. Things to consider during the FGD:
   - Encourage participants to actively involved in the FGD.
   - If there is a dominant participant, summarize the discussion and refocus to the question.
   - Use pause after asking a question to give participants time to think.
   - Ensure the recorder functions appropriately.

4. Procedures:
   a. To start, the researcher will briefly explain the research purposes and reasons to conduct a FGD.
   b. The researcher will explain the basic rules of FGD and the participants will be encouraged to follow the rules.
   c. The researcher will turn on the recorder.
   d. The researcher will give the opportunity to the participants to ask questions related to the FGD.
   e. The researcher will ask several questions according to particular groups.

      List of questions for student nurses:
      - What was your experience during the implementation of the clinical reflective practice model and the process used?
      - What do you think about the reflective activities that you used during the clinical placement?
        - Which activities did you find most useful and why?
        - Which activities did you find least useful and why?
        - Which activities did you find challenging?

- What was the role of clinical educator during the implementation of the model?
- What improvement would you suggest to implement the model?

List of questions for clinical educators:

- What was your experience during the implementation of the clinical reflective practice model and the process used?
- What do you think about the reflective activities which students used during the students' clinical placement?
  - The most successful?
  - The most challenging?
- From your experience as a clinical educator, can you identify any additional types of learning occurring in the reflective process for the students? (Compare previous experience of clinical placement to clinical placement using reflection?
- What value do you think the students gained from participating in this research project?
- What do you think about the reflective activities you used during the students' clinical placement for your professional growth?
- Did you use any additional teaching strategies beyond those promoted within the model?
- What should be improved from the model?

f. The researcher will give last opportunity for the participants to provide any additional information before the closing.

g. The researcher will end the discussion by saying thank you to the participants' involvement in the FGD.

Appendix K. Examples of Research News Update

RNU (16-09-13)

Research News Update...

--- A nurse educator is a pivotal person in developing reflective practitioners ---

This week, paediatric nursing specialist students are starting their residency period. At the end of this week, the students are expected to submit their web of causation (WOC), nursing care plans (NCP), implementation and evaluation documentations, and a reflective entry in their journal. All documents will be submitted using coloured plastic folders. In the following week, the students will submit their case summaries, documentations of implementation and evaluation actions, and another reflective entry, using the chosen nursing theory/model.

Clinical educators are expected to supervise students weekly and read their reflective journals. In the second week, the clinical educator is going to conduct individual reflective discussions with certain students focusing on their reflective entries in the journal.

Herewith some strategies to facilitate students in reflective discussion:

- Be specific in one interesting and important topic, and discuss any issues related to the topic
- Start with description of a situation, analysis, and evaluation (focus on next action in similar situation)
- Explore emotional issues arise as well
- Be aware of the time limit for each student

Next update will be about:

- Detail of time schedule for supervision
- Strategies to analyse reflective journals

Insya Allah, this work is done to improve our teaching/learning process in this residency period. Accordingly, students' and clinical educators' professional development will increase...

Best regards,

Dessie

RNU-SN (15-04-14)

Research News Update

--- The aim of reflection is to build bridges between past and present experiences to determine future nursing actions (Durgahee, 1998) ---

Praktik residensi akan segera berakhir dalam beberapa minggu ini. Semoga residen bisa dapat memanfaatkan waktu yang tersisa dengan lebih baik, sehingga pengalaman yang didapat bermanfaat untuk semakin mempersiapkan residen menjadi seorang Spesialis Keperawatan Anak.

Pada kesempatan ini Saya ingin menyampaikan dua hal terkait dengan Model Praktik Klinik Reflektif (MPKR) yang telah diimplementasikan sejak semester lalu.

- Ada tiga jenis refleksi yang bisa dilakukan oleh residen: Reflection-on-Action (RoA), Reflection-in-Action (RiA), dan Reflection-for-Action (RfA). Selama ini, residen telah melakukan RoA, dimana hal ini berarti refleksi dilakukan saat kejadian telah berlangsung. Hal ini biasa dilakukan oleh 'pemula' dalam praktik reflektif. Berdasarkan observasi yang telah dilakukan, beberapa residen telah melakukan RiA selama praktik klinik. Oleh karena itu, Saya menganjurkan residen untuk mencoba melaporkan RiA yang telah dilakukan pada reflective journal-nya. Contoh RiA adalah: "Saya melakukan komunikasi dengan klien an. S sesaat sebelum prosedur injeksi dilakukan. Namun, an. S terlihat tidak tertarik untuk merespon komunikasi yang dilakukan oleh perawat. Saya lalu memutuskan untuk menggunakan teknik komunikasi 'orang ketiga' pada an. S. Teknik itu saya lakukan dengan cara bla..bla..bla.."
- Diskusi reflektif dalam kelompok bisa dilakukan dengan beberapa cara. Cara (1) residen mengatur jadwal per 2 minggu siapa yang akan menyampaikan refleksinya. Cara (2) pada saat memulai diskusi, semua residen menyampaikan refleksi singkatnya, lalu anggota kelompok memilih refleksi yang dianggap penting atau menarik untuk dibahas lebih lanjut.

Semoga residen dapat belajar dari setiap kejadian, setiap pengalaman, setiap tugas yang telah dilalui. Smoga semua pembelajaran itu menjadikan residen lebih percaya diri saat dikukuhkan menjadi seorang Spesialis Keperawatan Anak.

Salam semangat,

Dessie

Appendix L. Examples of a student's reflective report in the 1st AR cycle

Praktik Reflektif

Diskripsi

Pemantauan intake dan output cairan di ruang non infeksi dicatat pada form yang sudah tersedia dan diisi oleh perawat. Informasi jumlah intake (minum) dan output (urin) didapatkan dari orang tua pasien. Orang tua melakukan pencatatan berupa jam, jumlah minum, jumlah urin. Pencatatan dilakukan menggunakan kertas atau buku milik pasien. Bentuk pencatatan tidak seragam, terkadang tulisan tidak jelas, sesuai kemampuan orang tua, sehingga sulit dipahami. Saya mengalami kesulitan saat akan memindahkan catatan orang tua ke dalam catatan kepe-rawatan. Orang tua juga seringkali lupa mencatat minum atau urin pasien.

Analisis.

Saya merasa pencatatan intake dan output yang dilakukan orang tua sangat membantu perawat. Hal ini juga tidak bertentangan dengan konsep PCC (family centered care) karena orang tua perlu dilibatkan dalam perawatan anak dan orang tualah yang berada di samping pasien selama 24 jam. Pencatatan memerlukan format yang baku dan mudah cara pemakaiannya sehingga orang tua juga lebih tepat dalam mencatat. Format yang jelas juga mempermudah orang lain membaca catatan tersebut.

Landasan teori

Shepherd (2011) memberikan contoh pencatatan intake dan output yang akurat. Pencatatan cairan dilakukan tiap jam, jenis minum ditulis dengan jelas dan semua dihitungkan dalam satuan ml.
Perawat merawat pasien bertanggung jawab untuk memastikan daftar isian balans cairan, mencatat secara reguler dan akurat.

Rencana tindakan.

- Membuat form intake output yang informatif dan mudah digunakan oleh pasien serta mudah dipahami.
- Saya melempar ide tersebut sebagai rencana proyek inovasi kelompok. (meskipun batal)

- Setelah terbentuk format, kami gandakan dan kami uji cobakan kepada orang tua pasien.
- Saat melakukan evaluasi ternyata respon orang tua sangat positif. Diantara pernyataan orang tua adalah :
  "enak, mengisinya gampang"
  "minta lagi dong suster, biar nanti saya fotokopi".
  "kalau seperti ini, enak suster, lebih jelas".

- Rencana tindakan untuk diri saya sendiri :
  - Saya merasa puas karena tindakan saya yang sederhana dapat bermanfaat bagi orang lain.
  - Saya menjadi paham bahwa meskipun perubahan yang saya lakukan bermanfaat, namun harus tetap dilandasi dasar ilmiah.
  - Saya lebih percaya diri untuk melakukan inovasi meskipun dari hal yang kecil atau sederhana.

Appendix M. Examples of a student's reflective report in the 2nd AR cycle

I. DOUBT / DIFFERENT

Saya merasa bersalah karena tidak dapat memberikan nutrisi parenteral Lipid (IL 20%) pada By. Ny. N sesuai terapi yang telah direncanakan.

II. DISCLOSURE

By. Ny. N yang lahir tgl 23 februari 2019 dan mendapat perawatan di SCN4, telah direncanakan mendapatkan nutrisi parenteral : lipid (IL 20%) sejak tanggal 21 februari sampai tanggal 3 maret 2019, namun terapi tersebut tidak diberikan. Terapi tidak diberikan karena keterbatasan alat (syringe pump), dan habisnya sediaan IL 20% di satelit farmasi. Pada tanggal 3 Maret, berat badan bayi menurun menjadi 1440 gram dari berat badan lahir 1745 gram.

III. DISSECTION

Pemberian lipid tidak diberikan karena alat pendukung berupa syringe pump tidak tersedia, dan saat alat tersedia malah cairan/nutrisi lipid (IL 20%) yang tidak tersedia karena kehabisan persediaan. Saya telah mengupayakan mendapatkan alat dengan bantuan perawat I, namun tetap tidak berhasil mendapatkan, serta saya telah 2kali ~~ke~~ ke farmasi pada farmasi namun sediaan belum ada. Ketidaktersediaan tersebut karena jumlah pasien/bayi yang dirawat di Perina mencapai BOR 120%, sehingga sarana dan prasarana terbatas. Perawat harus memprioritaskan penggunaan alat dan cairan serta obat-obatan untuk keburuhan kegawat daruratan, misalnya bayi yang menggunakan obat-obatan dopamin/

IV. DISCOVER

Salah satu peran perawat untuk membantu proses adaptasi pada neonatus adalah dengan konservasi energi, baik menyediakan energi yang cukup ataupun meminimalkan kehilangan energi. Lemak merupakan cadangan energi yang paling tinggi dibandingkan dengan karbohidrat dan protein. Pemberian nutrisi parenteral berupa lemak / lipid telah direkomendasikan oleh the American Academy of Pediatrics / AAP (2009) dengan kecepatan awal 0,5 – 1 gr/kgBB/hari yang dapat ditingkatkan 3 – 3,5 gr/kg BB/hari. Lipid selain menyediakan energi tinggi juga sebagai asam lemak essential (EFA) disebutkan mempunyai beberapa manfaat seperti membantu maturasi jaringan otak, sebagai pelarut vitamin (ADEK), dan sebagai antioksidan (penangkal radikal bebas) dari situasi hiperoksia masa-paru-paru yang dapat menyebabkan ROP dan CLD. Berbagai manfaat pemberian lipid tersebut menjadi dasar teori terapi nutrisi parenteral lemak pada neonatus, meskipun AAP belum mengemukakan kapan waktu terbaik memulai pemberiannya. Hasil sistimatik review menemukan bahwa tidak ada bukti yang signifikan (secara statistik) atas pemberian lipid awal (≤ 5 hari pertama lahir) terhadap tujuan jangka pendek nutrisi / klinis lainnya seperti growth rate, kematian dan CLP (chronic lung disease) (Simmer & Rao, 2005). Neu (2012) merekomendasikan dosis rendah mulai diberikan pada hari pertama atau kedua, dan tidak merekomendasikan pada bayi dengan kolestasis.

V. Dokter R menyarankan untuk melakukan penilaian lingkar kepala untuk mengetahui dampak pemberian lipid terhadap pertumbuhan dan perkembangan serta penilaian kondisi pernafasan dan stabilitas suhu untuk mengetahui dampaknya terhadap kondisi penyakit bayi. Hasilnya meskipun bayi mengalami penurunan berat badan namun bayi mengalami peningkatan lingkar kepala 0,5 cm (dalam satu minggu) dan kondisi pernapasan serta stabilitas suhu bayi baik, sehingga dapat disimpulkan bahwa tidak diberikannya lipid pada by.Ny.N tidak berdampak pada pertumbuhan otak dan kondisi / prognosis penyakit bayi.

VI. DESICION

Jika saya mengalami kejadian serupa, saya akan:

(1) Berusaha mengupayakan pemberian lipid mengingat manfaatnya yang besar sebagai penyedia energi yang tinggi dan adanya kandungan EFA.

(2) Namun jika terjadi dilema seperti ketersediaan alat dan bahan lipid seperti pada kasus ini, maka saya akan mengambil keputusan sesuai dengan prioritas, dengan memantau ketat efek / akibat yang mungkin timbul karena tidak diberikannya lipid. Pemantauan dilakukan pada aspek: berat badan, lingkar kepala, perburukan kondisi pernafasan dan adanya instabilitas suhu.

References

Adelman, C. 1993, 'Kurt Lewin and the origins of action research', *Educational Action Research*, vol. 1, no. 1, pp. 7-24.

Argyris, C. 1976, 'Single-loop and double-loop models in research on decision making', *Administrative Science Quarterly*, pp. 363-75.

Asosiasi Institusi Pendidikan Diploma III Keperawatan Indonesia 2015, *Sambutan Ketua AIPDiKI*, viewed 14 March 2015, <http://aipdiki.org/sambutan-ketua-aipdiki>.

Asselin, M.E. 2011, 'Using reflection strategies to link course knowledge to clinical practice: The RN-to-BSN student experience', *Journal of Nursing Education*, vol. 50, no. 3, pp. 125-33.

Association of Indonesian Nurse Education Center 2015, *Daftar anggota AIPNI*, AIPNI, Jakarta, viewed 14 March 2015, <http://www.aipni-ainec.com/?page=anggota_list&halaman=15&nama=&oke=>.

Badger, T.G. 2000, 'Action research, change and methodological rigour', *Journal of Nursing Management*, vol. 8, no. 4, pp. 201-7.

Bakioğlu, A. & Dalgiç, G. 2013, 'The possible barriers behind reflective thinking and practice: Experiences of school principals from Turkey and Denmark', *Educational Sciences: Theory & Practice*, vol. 13, no. 2, pp. 832-46.

Bensimon, E.M., Polkinghorne, D., Bauman, G. & Vallejo, E. 2004, 'Doing research that makes a difference', *The Journal of Higher Education*, vol. 75, no. 1, pp. 104-26.

Biskin, S., Barcroft, V., Livingston, W. & Snape, S. 2013, 'Reflections on Student, Service User and Carer Involvement in Social Work Research', *Social Work Education*, vol. 32, no. 3, pp. 301-16.

Boud, D. 2010, 'Relocating reflection in the context of practice', <URI: http://hdl.handle.net/10453/14325 >.

Boud, D.J., Keogh, R. & Walker, D. 1985, *Reflection: Turning experience into learning*, Kogan Page, England.

Bowl, M., Cooke, S. & Hockings, C. 2008, 'Researching across boundaries and borders: the challenges for research', *Educational Action Research*, vol. 16, no. 1, pp. 85-95.

Bradbury-Jones, C., Hughes, S.M., Murphy, W., Parry, L. & Sutton, J. 2009, 'A new way of reflecting in nursing: The Peshkin approach', *Journal of Advanced Nursing*, vol. 65, no. 11, pp. 2485-93.

Braine, M.E. 2009, 'Exploring new nurse teachers' perception and understanding of reflection: An exploratory study', *Nurse Education in Practice*, vol. 9, no. 4, pp. 262-70.

Brantlinger, E., Jimenez, R., Klingner, J., Pugach, M. & Richardson, V. 2005, 'Qualitative studies in special education', *Exceptional Children*, vol. 71, no. 2, pp. 195-207.

Bulman, C., Lathlean, J. & Gobbi, M. 2012, 'The concept of reflection in nursing: Qualitative findings on student and teacher perspectives', *Nurse Education Today*, vol. 32, no. 5, pp. e8-e13.

Bulman, C., Lathlean, J. & Gobbi, M. 2014, 'The process of teaching and learning about reflection: Research insights from professional nurse education', *Studies in Higher Education*, vol. 39, no. 7, pp. 1219-36.

Burnard, P. 1991, 'A method of analysing interview transcripts in qualitative research', *Nurse Education Today*, vol. 11, no. 6, pp. 461-6.

Burnard, P. 2005, 'Issues in helping students from other cultures', *Nurse Education Today*, vol. 25, no. 3, pp. 176-80.

Burnard, P. 2006, 'Some attitudes towards teaching and learning in Thai nursing education', *Nurse Education Today*, vol. 26, no. 3, pp. 253-7.

Burnard, P. & Naiyapatana, W. 2004, 'Culture and communication in Thai nursing: a report of an ethnographic study', *International Journal of Nursing Studies*, vol. 41, no. 7, pp. 755-65.

Burrows, A., Thomas, J., Woods, A., Suess, R. & Dole, D. 2012, 'Riding the wave: Student researcher reflection on the action research process', *Educational Action Research*, vol. 20, no. 2, pp. 291-312.

Cant, R.P. & Cooper, S.J. 2011, 'The benefits of debriefing as formative feedback in nurse education', *Australian Journal of Advanced Nursing*, vol. 29, no. 1, pp. 37-47.

Cardiff, S. 2012, 'Critical and creative reflective inquiry: Surfacing narratives to enable learning and inform action', *Educational Action Research*, vol. 20, no. 4, pp. 605-22.

Carr, W. & Kemmis, S. 2003, *Becoming critical: Education knowledge and action research*, Routledge, London.

Chambers, M.A. 1998, 'Some issues in the assessment of clinical practice: A review of the literature', *Journal of Clinical Nursing*, vol. 7, no. 3, pp. 201-8.

Chen, H.Y. & Boore, J.R. 2010, 'Translation and back-translation in qualitative nursing research: Methodological review', *Journal of Clinical Nursing*, vol. 19, no. 1-2, pp. 234-9.

Chiang, C.-K., Chapman, H. & Elder, R. 2010, 'Changing to learner-centred education: Challenges experienced by nurse educators in Taiwan', *Nurse Education Today*, vol. 30, no. 8, pp. 816-20.

Chong, M.C. 2009, 'Is reflective practice a useful task for student nurses?', *Asian Nursing Research*, vol. 3, no. 3, pp. 111-20.

Clarke, N.M. 2014, 'A person-centred enquiry into the teaching and learning experiences of reflection and reflective practice—Part one', *Nurse Education Today*, vol. 34, no. 9, pp. 1219-24.

Cleary, M., Horsfall, J., Happell, B. & Hunt, G.E. 2013, 'Reflective components in undergraduate mental health nursing curricula: Some issues for consideration', *Issues in Mental Health Nursing*, vol. 34, no. 2, pp. 69-74.

Cooke, M. & Matarasso, B. 2005, 'Promoting reflection in mental health nursing practice: A case illustration using problem-based learning', *International Journal of Mental Health Nursing*, vol. 14, no. 4, pp. 243-8.

Corey, S. 1949, 'Action research, fundamental research, and educational practices', *The Teachers College Record*, vol. 50, no. 8, pp. 509-14.

Costello, P.J. 2011, *Effective action research: Developing reflective thinking and practice*, Continuum International Publishing Group, London.

Cotton, A.H. 2001, 'Private thoughts in public spheres: Issues in reflection and reflective practices in nursing', *Journal of Advanced Nursing*, vol. 36, no. 4, pp. 512-9.

Coward, M. 2011, 'Does the use of reflective models restrict critical thinking and therefore learning in nurse education? What have we done?', *Nurse Education Today*, vol. 31, no. 8, pp. 883-6.

Cox, E. 2005, 'Adult learners learning from experience: Using a reflective practice model to support work-based learning', *Reflective Practice*, vol. 6, no. 4, pp. 459-72.

Cronin, M. & Connolly, C. 2007, 'Exploring the use of experiential learning workshops and reflective practice within professional practice development for post-graduate health promotion students', *Health Education Journal*, vol. 66, no. 3, pp. 286-303.

Curtin, M. & Fossey, E. 2007, 'Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists', *Australian Occupational Therapy Journal*, vol. 54, no. 2, pp. 88-94.

de Oliveira, S.N., Prado, M.L.d., Kempfer, S.S., Martini, J.G., Caravaca-Morera, J.A. & Bernardi, M.C. 2015, 'Experiential learning in nursing consultation education via clinical simulation with actors: Action research', *Nurse Education Today*, vol. 35, no. 2, pp. e50-e4.

Delany, C. & Watkin, D. 2009, 'A study of critical reflection in health professional education: 'Learning where others are coming from'', *Advances In Health Sciences Education*, vol. 14, no. 3, pp. 411-29.

Devita, G. 2000, 'Inclusive approaches to effective communication and active participation in the multicultural classroom: An international business management context', *Active Learning in Higher Education*, vol. 1, no. 2, pp. 168-80.

Dewey, J. 1998, *How we think: A restatement of the relation of reflective thinking to the educative process*, Houghton Mifflin, Boston.

Duffy, A. 2007, 'A concept analysis of reflective practice: Determining its value to nurses', *British Journal of Nursing*, vol. 16, no. 22, pp. 1400-7.

Duffy, A. 2009, 'Guiding students through reflective practice–The preceptors experiences. A qualitative descriptive study', *Nurse Education in Practice*, vol. 9, no. 3, pp. 166-75.

Duggan, R. 2005, 'Reflection as a means to foster client-centred practice', *Canadian Journal of Occupational Therapy*, vol. 72, no. 2, pp. 103-12.

Edelen, B.G. & Bell, A.A. 2011, 'The role of analogy-guided learning experiences in enhancing students' clinical decision-making skills', *The Journal of Nursing Education*, vol. 50, no. 8, pp. 453-60.

Ekebergh, M. 2011, 'A learning model for nursing students during clinical studies', *Nurse Education in Practice*, vol. 11, no. 6, pp. 384-9.

Ekintumas, D. 1999, 'Nursing in Thailand: Western concepts vs Thai tradition', *International Nursing Review*, vol. 46, no. 2, pp. 55-7.

Elcigil, A. & Sarı, H.Y. 2007, 'Determining problems experienced by student nurses in their work with clinical educators in Turkey', *Nurse Education Today*, vol. 27, no. 5, pp. 491-8.

Elliott, J. 1991, *Action research for educational change*, vol. 49, Open University Press Philadelphia.

Erden, N.S. 2013, 'Power Distance Leads to Corporate Grapevine: The Mediating Role of Perceptions of Uncertainty', *Journal of Multidisciplinary Research*, vol. 5, no. 1, p. 95.

Fleischer, S., Berg, A., Zimmermann, M., Wuste, K. & Behrens, J. 2009, 'Nurse-patient interaction and communication: A systematic literature review', *Journal of Public Health*, vol. 17, pp. 339-53.

Fock, H., Hui, M.K., Au, K. & Bond, M.H. 2012, 'Moderation effects of power distance on the relationship between types of empowerment and employee satisfaction', *Journal of Cross-Cultural Psychology*, p. 0022022112443415.

Forneris, S.G. & Peden-McAlpine, C. 2007, 'Evaluation of a reflective learning intervention to improve critical thinking in novice nurses', *Journal of Advanced Nursing*, vol. 57, no. 4, pp. 410-21.

Friberg, F. & Lyckhage, E.D. 2013, 'Changing essay writing in undergraduate nursing education through action research: A Swedish example', *Nursing Education Perspectives*, vol. 34, no. 4, pp. 226-32.

Gaberson, K.B., Oermann, M.H. & Shellenbarger, T. 2014, *Clinical teaching strategies in nursing*, Springer Publishing Company, New York.

Gartinah, T., Sitorus, R. & Irawaty, D. 2006, *Pelayanan profesionalisme keperawatan yang didukung oleh ilmu pengetahuan dan teknologi*, viewed 28 August 2014, <http://www.inna-ppni.or.id/index.php?name=News&file=article&sid=76>.

Getliffe, K.A. 1996, 'An examination of the use of reflection in the assessment of practice for undergraduate nursing students', *International Journal of Nursing Studies*, vol. 33, no. 4, pp. 361-74.

Ghaye, T. 2011, *Teaching and learning through reflective practice: A practical guide for positive action*, 2nd edn, Routledge, New York.

Gibbs, G. 1988, *Learning by doing: A guide to teaching & learning methods*, Further Education Unit, Oxford.

Gilbert, T. 2001, 'Reflective practice and clinical supervision: Meticulous rituals of the confessional', *Journal of Advanced Nursing*, vol. 36, no. 2, pp. 199-205.

Gillespie, M. & McFetridge, B. 2006, 'Nurse education–the role of the nurse teacher', *Journal of Clinical Nursing*, vol. 15, no. 5, pp. 639-44.

Glaze, J.E. 2001, 'Reflection as a transforming process: student advanced nurse practitioners' experiences of developing reflective skills as part of an MSc programme', *Journal of Advanced Nursing*, vol. 34, no. 5, pp. 639-47.

Glynn, D.M. 2012, 'Clinical judgment development using structured classroom reflective practice: A qualitative study', *Journal of Nursing Education*, vol. 51, no. 3, pp. 134-9.

Greenwood, D.J. & Levin, M. 2007, *Introduction to action research: Social research for social change*, 2nd edn, SAGE Publications, Inc., California.

Greenwood, J. 1994, 'Action research: a few details, a caution and something new', *Journal of Advanced Nursing*, vol. 20, no. 1, pp. 13-8.

Greenwood, J. 1998, 'The role of reflection in single and double loop learning', *Journal of Advanced Nursing*, vol. 27, no. 5, pp. 1048-53.

Grundy, S. 1982, 'Three modes of action research', *Curriculum Perspectives*, vol. 2, no. 3, pp. 23-34.

Hajbaghery, M.A. & Salsali, M. 2005, 'A model for empowerment of nursing in Iran', *BMC Health Services Research*, vol. 5, no. 1, p. 24.

Hall, C.C., Ariss, L. & Todorov, A. 2007, 'The illusion of knowledge: When more information reduces accuracy and increases confidence', *Organizational Behavior and Human Decision Processes*, vol. 103, no. 2, pp. 277-90.

Hancock, P. 1999, 'Reflective practice–using a learning journal', *Nursing Standard*, vol. 13, no. 17, pp. 37-40.

Hannigan, B. 2001, 'A discussion of the strengths and weaknesses of 'reflection' in nursing practice and education', *Journal of Clinical Nursing*, vol. 10, no. 2, pp. 278-83.

Hargreaves, J. 2004, 'So how do you feel about that? Assessing reflective practice', *Nurse Education Today*, vol. 24, no. 3, pp. 196-201.

Hart, E. 1996, 'Action research as a professionalizing strategy: Issues and dilemmas', *Journal of Advanced Nursing*, vol. 23, no. 3, pp. 454-61.

Harvey, M. 2013, 'So you think you are doing action research? Indicators of enactment of participatory action research in higher education', p. 115.

Hatlevik, I.K.R. 2012, 'The theory-practice relationship: reflective skills and theoretical knowledge as key factors in bridging the gap between theory and practice in initial nursing education', *Journal of Advanced Nursing*, vol. 68, no. 4, pp. 868-77.

Hennessy, D., Hicks, C., Hilan, A. & Kawonal, Y. 2006a, 'A methodology for assessing the professional development needs of nurses and midwives in Indonesia: Paper 1 of 3', *Human Resources for Health*, vol. 4, no. 1, p. 8.

Hennessy, D., Hicks, C., Hilan, A. & Kawonal, Y. 2006b, 'The training and development needs of nurses in Indonesia: Paper 3 of 3', *Human Resources for Health*, vol. 4, no. 1, p. 10.

Hilliard, C. 2006, 'Using structured reflection on a critical incident to develop a professional portfolio', *Nursing Standard*, vol. 21, no. 2, pp. 35-40.

Hofstede, G. 2011, 'Dimensionalizing cultures: The Hofstede model in context', *Online Readings in Psychology and Culture*, vol. 2, no. 1, p. 8.

Hofstede, G., Hofstede, G.J. & Minkov, M. 2010, *Cultures and organizations: Software of the mind*, 3rd edn, McGraw-Hill, USA.

Horton-Deutsch, S., McNelis, A.M. & Day, P.O. 2012, 'Developing a reflection-centered curriculum for graduate psychiatric nursing education', *Archives of Psychiatric Nursing*, vol. 26, no. 5.

Horton-Deutsch, S. & Sherwood, G. 2008, 'Reflection: An educational strategy to develop emotionally-competent nurse leaders', *Journal of Nursing Management*, vol. 16, no. 8, pp. 946-54.

Hughes, M. & Heycox, K. 2005, 'Promoting reflective practice with older people: Learning and teaching strategies', *Australian Social Work*, vol. 58, no. 4, pp. 344-56.

Human Research Ethics Committe 2013, 'HREC Policy for Undergraduate and Postgraduate Students', in S. University of Technology (ed.).

Ip, W.Y., Lui, M.H., Chien, W.T., Lee, I.F., Lam, L.W. & Lee, D.T. 2012, 'Promoting self-reflection in clinical practice among Chinese nursing undergraduates in Hong Kong', *Contemporary Nurse*, vol. 41, no. 2, pp. 253-62.

James, C.R. & Clarke, B.A. 1994, 'Reflective practice in nursing: Issues and implications for nurse education', *Nurse Education Today*, vol. 14, no. 82-90.

Jindal-Snape, D. & Holmes, E.A. 2009, 'A longitudinal study exploring perspectives of participants regarding reflective practice during their transition from higher education to professional practice', *Reflective Practice*, vol. 10, no. 2, pp. 219-32.

Johns, C. 1999, 'Reflection as empowerment?', *Nursing Inquiry*, vol. 6, no. 4, pp. 241-9.

Johns, C. 2009, *Becoming a reflective practitioner*, 3rd edn, Wiley-Blackwell, United Kingdom.

Johns, C. & Watson, J. 2000, *Becoming a reflective practitioner: A reflective and holistic approach to clinical nursing, practice development and clinical supervision*, Blackwell Science Oxford, Oxford.

Jones, S. & Gelling, L. 2013, 'Participation in action research', *Nurse Researcher*, vol. 21, no. 2, pp. 6-7.

Joyce-McCoach, J.T., Parrish, D.R., Andersen, P.R. & Wall, N. 2013, 'Unlocking reflective practice for nurses: Innovations in working with master of nursing students in Hong Kong', *Nurse Education in Practice*, vol. 13, no. 5, pp. 388-92.

Kapoor, S., Hughes, P.C., Baldwin, J.R. & Blue, J. 2003, 'The relationship of individualism–collectivism and self-construals to communication styles in India and the United States', *International Journal of Intercultural Relations*, vol. 27, no. 6, pp. 683-700.

Kawashima, A. & Petrini, M.A. 2004, 'Study of critical thinking skills in nursing students and nurses in Japan', *Nurse Education Today*, vol. 24, no. 4, pp. 286-92.

Kemmis, S. 1996, 'Action research in retrospect and prospect', in S. Kemmis & R. McTaggart (eds), *The action research reader*, 3rd edn, Deakin University, Victoria, pp. 27-39.

Kemmis, S. & McTaggart, R. 1988, *The Action research planner*, 3rd edn, Deakin University, Victoria.

Kim, H.S. 1999, 'Critical reflective inquiry for knowledge development in nursing practice', *Journal of Advanced Nursing*, vol. 29, no. 5, pp. 1205-12.

King, N. 2012, 'Doing template analysis', *Qualitative organizational research: Core methods and current challenges*, pp. 426-250.

Kinsella, E.A. 2010, 'Professional knowledge and the epistemology of reflective practice', *Nursing Philosophy: An International Journal For Healthcare Professionals*, vol. 11, no. 1, pp. 3-14.

Kolb, D.A., Boyatzis, R.E. & Mainemelis, C. 2001, 'Experiential learning theory: Previous research and new directions', *Perspectives on thinking, learning, and cognitive styles*, vol. 1, pp. 227-47.

Krefting, L. 1991, 'Rigor in qualitative research: The assessment of trustworthiness', *American Journal of Occupational Therapy*, vol. 45, no. 3, pp. 214-22.

Kusumawati, D. 2010, 'Exploring student-centred teaching, open-ended tasks, and real data analysis to promote students' reasoning about variation', Universiteit van Amsterdam, Amsterdam.

Kuswandono, P. 2014, 'University mentors' views on reflective practice in microteaching: Building trust and genuine feedback', *Reflective Practice*, vol. 15, no. 6, pp. 701-17.

Larsson, H. & Blomqvist, K. 2015, 'From a diagnostic and particular approach to a person-centred approach: A development project', *Journal of Clinical Nursing*, vol. 24, no. 3-4, pp. 465-74.

Laverty, J. 2012, 'Reflective learning within clinical physiology: The student's perspective on the usefulness of reflection as a learning tool', *Reflective Practice*, vol. 13, no. 1, pp. 131-47.

Leijen, Ä., Lam, I., Wildschut, L. & Simons, P.R.-J. 2009, 'Difficulties teachers report about students' reflection: Lessons learned from dance education', *Teaching in Higher Education*, vol. 14, no. 3, pp. 315-26.

Leung, K.H., Pluye, P., Grad, R. & Weston, C. 2010, 'A reflective learning framework to evaluate cme effects on practice reflection', *Journal of Continuing Education in the Health Professions*, vol. 30, no. 2, pp. 78-88.

Lewin, K. 1946, 'Action research and minority problems', *Journal of Social Issues*, vol. 2, no. 4, pp. 34-46.

Li, W. 2009, 'Online knowledge sharing among Chinese and American employees: Explore the influence of national cultural differences', *International Journal of Knowledge Management*, vol. 5, no. 3, pp. 54-72.

Lie, D., Shapiro, J., Cohn, F. & Najm, W. 2010, 'Reflective practice enriches clerkship students' cross-cultural experiences', *Journal of General Internal Medicine*, vol. 25 no. 2, pp. 119-25.

Lincoln, Y.S. & Guba, E.G. 1985, 'Establishing trustworthiness', *Naturalistic Inquiry*, vol. 289, p. 331.

Lutz, G., Scheffer, C., Edelhaeuser, F., Tauschel, D. & Neumann, M. 2013, 'A reflective practice intervention for professional development, reduced stress and improved patient care—A qualitative developmental evaluation', *Patient Education and Counseling*, vol. 92, no. 3, pp. 337-45.

Manning, A., Cronin, P., Monaghan, A. & Rawlings-Anderson, K. 2009, 'Supporting students in practice: An exploration of reflective groups as a means of support', *Nurse Education in Practice*, vol. 9, no. 3, pp. 176-83.

Marambe, K.N., Vermunt, J.D. & Boshuizen, J.P.A. 2012, 'A cross-cultural comparison of student learning patterns in higher education', *Higher Education*, vol. 64, pp. 299-316.

Matusitz, J. & Musambira, G. 2013, 'Power distance, uncertainty avoidance, and technology: Analyzing Hofstede's dimensions and human development indicators', *Journal of Technology in Human Services*, vol. 31, no. 1, pp. 42-60.

McBrien, B. 2007, 'Learning from practice-Reflections on a critical incident', *Accident and Emergency Nursing*, vol. 15, no. 3, pp. 128-33.

McCormack, B. & McCance, T.V. 2006, 'Development of a framework for person-centred nursing', *Journal of Advanced Nursing*, vol. 56, no. 5, pp. 472-9.

McCormack, B. & Titchen, A. 2006, 'Critical creativity: Melding, exploding, blending', *Educational Action Research*, vol. 14, no. 2, pp. 239-66.

McIntosh, P. 2010, *Action research and reflective practice: Creative and visual methods to facilitate reflection and learning*, Routledge, New York.

McNiff, J., Lomax, P. & Whitehead, J. 2003, *You and your research project*, RoutlegdeFalmer, London.

McNiff, J. & Whitehead, J. 2011, *All you need to know about action research*, Sage Publications, London.

Mercer, J. 2007, 'The challenges of insider research in educational institutions: Wielding a double-edged sword and resolving delicate dilemmas', *Oxford Review of Education*, vol. 33, no. 1, pp. 1-17.

Merkin, R.S. 2006, 'Uncertainty avoidance and facework: A test of the Hofstede model', *International Journal of Intercultural Relations*, vol. 30, no. 2, pp. 213-28.

Minnis, J.R. 1999, 'Is reflective practice compatible with Malay-Islamic values? Some thoughts on teacher education in Brunei Darussalam', *Australian Journal of Education*, vol. 43, no. 2, pp. 172-85.

Montgomery, P. & Bailey, P. 2007, 'Field notes and theoretical memos in grounded theory', *Western Journal of Nursing Research*, vol. 29, no. 1, pp. 65-79.

Morgan, J., Rawlinson, M. & Weaver, M. 2006, 'Facilitating online reflective learning for health and social care professionals', *Open Learning*, vol. 21, no. 2, pp. 167-76.

Morris, J. & Stew, G. 2007, 'Collaborative reflection: How far do 2:1 models of learning in the practice setting promote peer reflection?', *Reflective Practice*, vol. 8, no. 3, pp. 419-32.

Mulhall, A. 2003, 'In the field: Notes on observation in qualitative research', *Journal of Advanced Nursing*, vol. 41, no. 3, pp. 306-13.

Muratbekova-Touron, M. 2002, 'Working in Kazakhstan and Russia: Perception of French managers', *International Journal of Human Resource Management*, vol. 13, no. 2, pp. 213-31.

Murphy, J.I. 2004, 'Using focused reflection and articulation to promote clinical reasoning: An evidence-based teaching strategy', *Nursing Education Perspectives*, vol. 25, no. 5, pp. 226-31.

National Health and Medical Research Council 2007, 'Australian code for the responsible conduct of research', in A. Goverment (ed.)Australia.

Ndubisi, N.O., Malhotra, N.K., Ulas, D. & Ndubisi, G.C. 2012, 'Examining uncertainty avoidance, relationship quality, and customer loyalty in two cultures', *Journal of International Consumer Marketing*, vol. 24, no. 5, pp. 320-37.

O'Sullivan, A.J., Howe, A.C., Miles, S., Harris, P., Hughes, C.S., Jones, P., Scicluna, H. & Leinster, S.J. 2012, 'Does a summative portfolio foster the development of capabilities such as reflective practice and understanding ethics? An evaluation from two medical schools', *Medical Teacher*, vol. 34, no. 1, pp. e21-e8.

Orb, A., Eisenhauer, L. & Wynaden, D. 2001, 'Ethics in qualitative research', *Journal of Nursing Scholarship*, vol. 33, no. 1, pp. 93-6.

Paget, T. 2001, 'Reflective practice and clinical outcomes: Practitioners' views on how reflective practice has influenced their clinical practice', *Journal of Clinical Nursing*, vol. 10, no. 2, pp. 204-14.

Patton, N., Higgs, J. & Smith, M. 2011, 'Envisioning visual research strategies', in J. Higgs, A. Titchen, D. Horsfall & D. Bridges (eds), *Creative spaces for qualitative researching: Living research*, Sense Publisher, Rotterdam.

Peden-McAlpine, C., Tomlinson, P.S., Forneris, S.G., Genck, G. & Meiers, S.J. 2005, 'Evaluation of a reflective practice intervention to enhance family care', *Journal of Advanced Nursing*, vol. 49, no. 5, pp. 494-501.

Phillips, D.K. & Carr, K. 2015, *Becoming a teacher through action research: Process, context, and self-study*, 3rd edn, Routledge, New York.

Pizam, A. & Fleischer, A. 2005, 'The relationship between cultural characteristics and preference for active vs passive tourist activities', *Journal of Hospitality & Leisure Marketing*, vol. 12, no. 4, pp. 5-25.

Plack, M., Dunfee, H., Rindflesch, A. & Driscoll, M. 2008, 'Virtual action learning sets: A model for facilitating reflection in the clinical setting', *Journal of Physical Therapy Education*, vol. 22, no. 3, pp. 33-42.

Plack, M. & Santasier, A. 2003, 'Reflective practice: A model for facilitating critical thinking skills within an integrative case study classroom experience', *Journal of Physical Therapy Education*, vol. 18, no. 1, pp. 4-12.

Platzer, H., Blake, D. & Ashford, D. 2000, 'Barriers to learning from reflection: A study of the use of groupwork with post-registration nurses', *Journal of Advanced Nursing*, vol. 31, no. 5, pp. 1001-8.

Polit, D.F. & Beck, C.T. 2014, *Essentials of nursing research: Appraising evidence for nursing practice*, 8th edn, Lippincott Williams & Wilkins, Philadelphia.

Reason, P. & Bradbury, H. 2001, *Handbook of action research: Participative inquiry and practice*, Sage Publications Ltd., London.

Reason, P. & Bradbury, H. 2006, *Handbook of action research: Concise paperback edition*, SAGE Publication Ltd, London.

Reed, J. 2005, 'Using action research in nursing practice with older people: Democratizing knowledge', *Journal of Clinical Nursing*, vol. 14, no. 5, pp. 594-600.

Rees, K.L. 2013, 'The role of reflective practices in enabling final year nursing students to respond to the distressing emotional challenges of nursing work', *Nurse Education in Practice*, vol. 13, no. 1, pp. 48-52.

Reilly, B.M. 2007, 'Inconvenient truths about effective clinical teaching', *The Lancet*, vol. 370, no. 9588, pp. 705-11.

Richardson, P.M. 2004, 'Possible influences of Arabic-Islamic culture on the reflective practices proposed for an education degree at the Higher Colleges of Technology in the United Arab Emirates', *International Journal of Educational Development*, vol. 24, no. 4, pp. 429-36.

Roche, A. & Coote, S. 2008, 'Focus group study of student physiotherapists' perceptions of reflection', *Medical Education*, vol. 42, no. 11, pp. 1064-70.

Rolfe, G. 1996, *Closing the theory -practice gap: A new paradigm for nursing*, Reed Educational and Professional Publishing Ltd., Oxford.

Rolfe, G. 2006, 'Validity, trustworthiness and rigour: Quality and the idea of qualitative research', *Journal of Advanced Nursing*, vol. 53, no. 3, pp. 304-10.

Rolfe, G., Jasper, M. & Freshwater, D. 2010, *Critical reflection in practice: Generating knowledge for care*, 2nd edn, Palgrave Macmillan, Basingstoke.

Ruth-Sahd, L.A. 2003, 'Reflective practice: A critical analysis of data-based studies and implications for nursing education', *Journal of Nursing Education*, vol. 42, no. 11, pp. 488-97.

Samba, S. 2012, *Perjalanan keperawatan Indonesia*, Yayasan Nursentra Bandung, Bandung.

Sanders, D. & McCutcheon, G. 1984, 'On the evolution of teachers' theories of action through action research', *Paper. Dptment. of Educational Policy and Leadeship. OHIO State University*.

Santoro, N. 2009, 'Teaching in culturally diverse contexts: What knowledge about 'self'and 'others' do teachers need?', *Journal of Education for Teaching*, vol. 35, no. 1, pp. 33-45.

Santos, H.P., Black, A.M. & Sandelowski, M. 2014, 'Timing of translation in cross-language qualitative research', *Qualitative Health Research*, p. 1049732314549603.

Sapsford, R. & Jupp, V. 2006, *Data collection and analysis*, SAGE Publications Ltd., London.

Schön, D.A. 1983, *The reflective practitioner: How professionals think in action* Basic Books, New York.

Schön, D.A. 1987, *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions*, Jossey-Bass, Inc. , San Francisco.

Seib, C., English, R. & Barnard, A. 2011, 'Teaching undergraduate students community nursing: Using action research to increase engagement and learning', *Journal of Nursing Education*, vol. 50, no. 9, pp. 536-9.

Seidman, I. 2013, *Interviewing as qualitative research: A guide for researchers in education and the social sciences*, Teachers College Press, New York.

Siriwanij, W. 2002, 'Learning through reflective practice in nursing clinical education in Thailand', University of New South Wales, Sydney.

Smith, A. & Jack, K. 2005, 'Reflective practice: A meaningful task for students', *Nursing Standard*, vol. 19, no. 26, pp. 33-7.

Snoeren, M.M., Niessen, T.J. & Abma, T.A. 2011, 'Engagement enacted: Essentials of initiating an action research project', *Action Research*, p. 1476750311426620.

Statistics Indonesia, National Population and Family Board, Ministry of Health & ICF International 2013, *Indonesia demographic and health survey 2012*, Jakarta.

Stockhausen, L. & Kawashima, A. 2002, 'The introduction of reflective practice to Japanese nurses', *Reflective Practice: International and Multidisciplinary Perspectives*, vol. 3, no. 1, pp. 117-29.

Stockhausen, L.J. 2005, 'Learning to become a nurse: Students' reflections on their clinical experiences', *Australian Journal of Advanced Nursing*, vol. 22, no. 3, pp. X8-14.

Stockhausen, L.J. 2007, 'Developing culturally competent reflective practitioners. Part 1. Cultural reflections', *Asian Journal of Nursing*, vol. 10, no. 4, pp. 212-7.

Stockhausen, L.J. & Serizawa, A. 2008, 'Developing culturally competent reflective practitioners. Part 2. The culturally responsive reflective practice model', *Asian Journal of Nursing*, vol. 11, no. 1, pp. 8-12.

Streubert, H.J. & Carpenter, D.R. 2011, *Qualitative research in nursing: Advancing the humanistic imperative*, 5th edn, Wolters Kluwer Health, Philadelphia.

Stringer, E.T. 2007, *Action research*, SAGE Publications, Inc., California.

Tay, L.H., Hegney, D. & Ang, E. 2011, 'Factor affecting effective communication between registered nurses and adult cancer patients in an inpatient setting: A systematic review', *International Journal of Evidence-Based Healthcare*, vol. 9, pp. 151-64.

Taylor, B. & Francis, K. 2013, *Qualitative research in the health sciences: Methodologies, methods and processes*, Routledge, Oxon.

Taylor, B.J. 2010, *Reflective practice for healthcare professionals: A practical guide*, 3rd edn, Open University Press, New York.

Teekman, B. 2000, 'Exploring reflective thinking in nursing practice', *Journal of Advanced Nursing*, vol. 31, no. 5, pp. 1125-35.

Thompson, N. & Pascal, J. 2012, 'Developing critically reflective practice', *Reflective Practice*, vol. 13, no. 2, pp. 311-25.

Titchen, A. 2015, 'Action research: Genesis, evolution and orientations', *International Practice Development Journal*, vol. 5, no. 1, pp. 1-16.

Titchen, A. & Binnie, A. 1993, 'Research partnerships: Collaborative action research in nursing', *Journal of Advanced Nursing*, vol. 18, no. 6, pp. 858-65.

Titchen, A. & Horsfall, D. 2011, 'Embodying creative imagination and expression in qualitative research', in J. Higgs, A. Titchen, D. Horsfall & D. Bridges (eds), *Creative spaces for qualitative researching: Living research*, Sense Publisher, Rotterdam.

Tobin, G.A. & Begley, C.M. 2004, 'Methodological rigour within a qualitative framework', *Journal of Advanced Nursing*, vol. 48, no. 4, pp. 388-96.

Torsvik, M. & Hedlund, M. 2008, 'Cultural encounters in reflective dialogue about nursing care: A qualitative study', *Journal of Advanced Nursing*, vol. 63, no. 4, pp. 389-96.

Trede, F. & Smith, M. 2012, 'Teaching reflective practice in practice settings: students' perceptions of their clinical educators', *Teaching in Higher Education*, vol. 17, no. 5, pp. 615-27.

Triandis, H.C. 1995, *Individualism & collectivism*, Westview Press, Colorado.

Triandis, H.C., McCusker, C. & Hui, C.H. 1990, 'Multimethod probes of individualism and collectivism', *Journal of Personality and Social Psychology*, vol. 59, no. 5, pp. 1006-20.

Turale, S., Ito, M., Murakami, K. & Nakao, F. 2009, 'Nursing scholarship in Japan: Development, facilitators, and barriers', *Nursing & Health Sciences*, vol. 11, no. 2, pp. 166-73.

Turnock, C. & Gibson, V. 2001, 'Validity in action research: a discussion on theoretical and practice issues encountered whilst using observation to collect data', *Journal of Advanced Nursing*, vol. 36, no. 3, pp. 471-7.

Van Nes, F., Abma, T., Jonsson, H. & Deeg, D. 2010, 'Language differences in qualitative research: Is meaning lost in translation?', *European Journal of Ageing*, vol. 7, no. 4, pp. 313-6.

Varela, O.E. & Premeaux, S.F. 2008, 'Do Cross-Cultural Values Affect Multisource Feedback Dynamics? The Case of High Power Distance and Collectivism in Two Latin American Countries', *International Journal of Selection and Assessment*, vol. 16, no. 2, pp. 134-42.

Wanda, D., Wilson, V. & Fowler, C. 2014, 'East meets West in reflective practice', *Nurse Education Today*, vol. 34, no. 12, pp. 1417-9.

Wen, C.-C., Lin, M.-J., Lin, C.-W. & Chu, S.-Y. 2015, 'Exploratory study of the characteristics of feedback in the reflective dialogue group given to medical students in a clinical clerkship', *Medical Education Online*, vol. 20, no. 0, pp. 1-9.

White, D.E., Oelke, N.D. & Friesen, S. 2012, 'Management of a large qualitative data set: Establishing trustworthiness of the data', *International Journal of Qualitative Methods*, vol. 11, no. 3, pp. 244-58.

Williamson, G., Bellman, L. & Webster, J. 2012, *Action research in nursing and healthcare*, SAGE Publications Ltd, London.

Wilson, G. 2011, 'Evidencing reflective practice in social work education: Theoretical uncertainties and practical challenges', *British Journal of Social Work*, p. bcr170.

Wilson, V., McCormack, B. & Ives, G. 2006, 'Re-generating the 'self' in learning: Developing a culture of supportive learning in practice', *Learning in Health and Social Care*, vol. 5, no. 2, pp. 90-105.

Wong, L.P. 2008, 'Focus group discussion: A tool for health and medical research', *Singapore Medical Journal*, vol. 49, no. 3, pp. 256-60.

World Bank 2014, *Indonesia*, viewed 05 September 2014, <http://data.worldbank.org/country/indonesia>.

World Health Organization 2014, *Indonesia*, viewed 01 September 2014, <http://www.who.int/countries/idn/en/>.

Zuber-Skerritt, O. & Perry, C. 2002, 'Action research within organisations and university thesis writing', *The Learning Organization*, vol. 9, no. 4, pp. 171-9.