

Developing an innovated Flexible Clinical Education Model: Enhancing student learning

Karen Lawrence

Master of Health Science
GradDip Vocational Education and Training
GradDip Midwifery
Bachelor of Nursing
Registered Nurse

A thesis submitted in partial fulfilment for the degree of
Doctor of Education, College of Education
Victoria University Melbourne Australia

2014

Declaration of Originality

I, Karen Lawrence declare that the EdD thesis entitled *Developing an innovated Flexible Clinical Education Model: Enhancing student learning* is no more than 60,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.



Signed: _____

on: 1 / 09 / 2014

Acknowledgements

It is with a great sense of satisfaction and relief that I have reached my goal and completed this thesis. I extend my sincere thanks to the following people.

I would like to express my appreciation and thanks to my supervisors Associate Professor Colleen Vale and Dr Marcelle Cacciattolo. Their generous input of time, energy and enthusiasm along with their critical comment and continued guidance has been a wonderful source of motivation and encouragement. Thank you to professional editor, Dr. Ian Ling for providing copyediting and proofreading services, according to the guidelines laid out in the university-endorsed national guidelines, 'The editing of research theses by professional editors'.

I would like to thank all the participants in this study. This includes the many nursing students, preceptors and academic staff who were involved in the individual or focus group interviews. Without their commitment the study would not have been possible. A particular thank you to the four wards where I conducted participant observations over extended weeks and for their willingness to share their work day with me.

I would also like to acknowledge and thank the staff at Hospital X (pseudonym) for the support they provided with respect to the development, implementation and evaluation of the Flexible Clinical Education Model. The continued willingness and commitment of staff to work collaboratively towards a better way to provide quality clinical learning for undergraduate nursing students was exemplary.

Finally I would like to thank my family who have patiently lived this journey with me. My husband Gary and children Emma, Megan and Patrick have been understanding while providing unwavering support and encouragement, without which I could not have completed this thesis. A special thank you is extended to my parents Cynthia and Stan, who instilled the love of reading in me at a very early age and showed continued interest in all my goals and aspirations.

Abstract

The purpose of this study was to enhance the clinical experience of undergraduate nursing students through an investigation into a Flexible Clinical Education Model offered at Victoria University.

Clinical education is a vital component of the undergraduate nursing curriculum that provides students with the opportunity to develop the knowledge, attitudes and skills needed to function effectively as a qualified nurse. Despite the commitment of universities to produce competent graduates, there is continued debate regarding models of clinical education that provide best practice in the clinical learning environment.

The hospital that was involved in this study was part of a larger organisation of public health care. This study involved interviewing clinical staff from four wards across Hospital X, academic staff and final semester, undergraduate nursing students from Victoria University.

Ethnography was chosen for this study because it supports the theory of social learning, which informs the Flexible Clinical Education Model. Ethnographic fieldwork was especially well suited to studying interactions among members of a defined community, such as the relations between clinicians and students in a ward environment. Ethnography provided a useful approach that facilitated mutual dialogue among participants, and enabled the researcher to be immersed in a group for an extended period of time, observing behaviour, listening to conversations and asking questions.

The findings of this study show that the Flexible Clinical Education Model enhanced the practical learning experience for undergraduate nursing students. The results also indicated that staff, both clinical and academic, valued the Flexible Clinical Education Model as a favourable model of clinical learning. Key features found to be important in facilitating these outcomes included the collaborative nature of the Flexible Clinical Education Model and a sense of

Frontispiece

ownership by staff and students alike. These factors showed a community of practice (Wenger 1998) was in place that enabled the development of positive learning environments in the wards where students were allocated for clinical experience.

List of publications and awards

Publications

Lawrence, K. (2014) Innovation in Clinical Practice: Providing undergraduate nursing students with a Best Practice Clinical Learning Environment.. *Journal of Teaching and Education*. 3(1):265-274

Conference papers

Lawrence, K. (2013). *Innovation in Clinical Practice: Providing undergraduate nursing students with a best practice clinical learning environment*. Paper presented at the meeting of the International Journal of Arts and Science, Multidisciplinary Academic Conference, Rome.

Lawrence, K. (2012) *Innovation in clinical practice: Providing undergraduate nursing students with an ideal clinical experience*. 14th National Nurse Education Conference, Perth.

Lawrence, K. (2010). *Case Study: Implementing a flexible model of clinical education into an undergraduate nursing curriculum*. Clinical Training and Workforce Planning Summit, Melbourne.

Autoethnography

This foreword has been written in the first person as it is my personal reflection of how I entered into nursing, transitioned into education and became interested in student learning in the clinical environment. This foreword locates my personal context and describes how it led to my passion in the nursing sector. Many factors influenced my desire to contribute to academic discourse around elements that shape innovation and excellence in nursing programs.

Growing up as the youngest of six children, dinner time was always hectic but full of wonderful stories. My mother and two older sisters all had nursing backgrounds and would enlighten the remaining members of the family with anecdotal stories of events they had experienced along the way. Tales of wandering patients with Alzheimer's to the removal of drain tubes were discussed; it seemed nothing was off limits. These discussions provided me with a sense of awe and wonderment about the nursing profession: initially, however, these kinds of discussions were not enough to entice me into nursing.

After completing my secondary education I was still unsure which career path I should take. A direct result of this uncertainty was that I decided to take 12 months to reflect on life and what I wanted from it. I guess this is now more commonly referred to as a 'gap' year but back then it was a time to think about where I wanted to be in the future. With this in mind, I commenced my first paid employment on a stud farm at the base of Mt Macedon. I thought I had found the perfect job. Surrounded by a small group of people, I learnt everything about stud management including siring, foaling, weaning and yearling preparation. I was a complete novice and my colleagues at the time used a great deal of sharing and storytelling to teach me about the craft of this trade. As a result, my expertise and confidence grew quickly. It was only after the first winter that I decided that an indoor job might be more suitable!

At this point my mother started hinting at nursing. Initially I wasn't interested but with some persuasion I applied for the 12 month Enrolled Nurse (EN) course at Heidelberg Repatriation Hospital (Victoria). As this was only a short course it seemed like an ideal compromise: I still was not convinced that I wanted to be a nurse.

So, I packed my meagre belongings and moved into the second floor of the nurses' home and for the first six weeks undertook what was known as PTS – Preliminary Training School. It was during PTS that we were 'taught' how to care for people. I am careful choosing the words here, as PTS was more about teaching than learning. We had sets of skills to acquire and competencies to achieve, but with no practical application it was difficult to comprehend the need for such skills. It was only after successfully passing all my theoretical exams during this six week period that we were unleashed upon 'real' patients. It was then that the real learning began and my passion for the nursing profession ensued.

I still vividly remember my first ward: the Head and Neck Plastics Ward. It was 1984, some 40 years post-World War II, and all the patients in this hospital belonged to the Department of Veteran Affairs (DVA). There were a lot of oral cancers on this ward; the theory linked behind this was related to the tobacco chewed during service time as tobacco use by soldiers was prevalent throughout the twentieth-century. Additionally, tobacco was viewed as a booster to a soldier's morale and was argued to provide comfort and to reduce stress in harsh conditions. During the 1940s, commando raids were carried out by land and sea. The destructive nature of these commando attacks on these veterans and the connection between the radical nature of oral surgery on soldiers led to the term 'Commando' surgery being coined (Martin 1957). It is still the operation known today that consists of removal of a primary tumour in the mandible (lower jaw) and neck. Some of these surgeries were experimental and most outcomes were horrific for staff, patients and their families.

My first patient was no exception. He had undergone radical surgery to remove a tumour from his mandible. In fact a large section of his mandible had been removed and his left great toe had been amputated and grafted in its place. He had a flap of muscle and skin from his chest attached to his mandible that supplied blood and vital nutrients to the newly grafted area. No amount of PTS could have prepared me for this sight.

I worked with a wonderful nurse who was kind and gentle with her explanations of our expected nursing responsibilities of this type of surgery. Barbara* (not her real name) showed me how to clean the skin graft and explained what to look for when assessing for signs of rejection. She explained colours and described smells that suggested a particular kind of bacteria. All of these explanations were based on Barbara's own professional experience. I learnt a lot from Barbara. Not just about nursing skills but I picked up on some of her mannerisms that I still use to this day. At the start of every shift she would greet her patients with 'Good morning/afternoon/evening', ensuring that each patient was treated as an equal. In the three months that I worked on that ward I never saw Barbara speak to a patient in a condescending or belittling tone. To me, this was a significant and powerful observation.

I adopted many of my colleagues' characteristics, slowly building my own repertoire. Not all senior nurses were friendly though and nurses have a strong capacity to 'eat their young'. This expression is almost a standard among nurses: it refers to bullying or harassment. A vivid example of this is when after a few weeks on the ward I asked a nurse what the difference was between a 'nurse bank' and a 'nurse pool'. I had heard these terms used interchangeably during my shift work and was unclear of their meanings. Her answer was short and sharp. She exclaimed in a matter of fact tone, 'nurse bank is where we keep our money and nurse pool is where we swim'. I was so embarrassed by her harshness that I didn't ask any more questions for weeks – this impeded my learning and did little to boost my own confidence on the ward. This incident occurred in 1984, almost 30 years ago, but the

embarrassment I felt is still a strong memory and acts as a powerful reminder of how not to treat junior staff or any colleague that I work with.

I completed my 12 months EN training but was still unsure whether nursing was for me; consequently I filled a backpack with some belongings and headed off to Europe for 12 months. On my return to Australia I worked in a variety of non-nursing jobs and at the age of 24 years my deep seated interest for the nursing profession was once again fuelled and I applied to Victoria University and was accepted into the Bachelor of Nursing in 1990. The curriculum has changed many times since my initial nursing training but one thing has remained constant: the need for quality clinical placements.

The Nursing Board of Victoria (now under AHPRA) have very strict rules on the duration of clinical placement in the Bachelor of Nursing and where they are to be held. During my course, I never thought about how the placements were sought or how they were arranged; I simply just attended where I was scheduled to go. I remember feeling awkward for the first few days while I settled into the swing of ward life. Having to learn new terminologies and being exposed to new experiences meant a lot of time away from my patients while I looked up unknown or unfamiliar procedures. After the third day I was comfortable in the new environment and ready to learn but I noticed some of my younger peers struggled with the changing environment and new staff. Often, the younger students would stay close to my side until they felt comfortable to 'go it alone'. I don't want you to think that I am a saint because sometimes I was annoyed by how I was being treated by nursing mentors; their treatment often hindered me from feeling a part of the team. Yet despite my own uncertainties I felt I needed to support the younger students when they approached me because I empathised with them, especially as a result of my own first ward experience in 1984.

Not all wards provided a positive learning environment. One of my final year placements was at a private hospital in Melbourne and this was by far the most inhospitable clinical placement that I experienced. The ward staff made no attempt to speak with the students and openly commented on how annoying

it was to have them there. At the start of each shift the Nursing Unit Manager (NUM) would say, “OK, we have two Victoria University students with us today so who ‘wants’ them?” This request almost always followed a long period of awkward silence. This would be followed by comments from the nurses, such as, ‘had them yesterday’ or ‘they slow me down’ and my personal favourite ‘not me, I don’t like students’! Ah, yes of course this nurse must have gone straight from secondary school to becoming a registered nurse! As students you quickly learnt to develop a thick skin and not to let negative comments such as these bother you.

Over my four week placement, comments such as these were expressed daily by nursing staff. I became self-confident after the first two weeks and took the lead at handover by asking the NUM, “I had beds 1 – 4 yesterday; could I have these again?” I felt this strategy gave me some input and direction to my day and gave me initiative to be actively involved in my placement. Of course it didn’t always work. At the completion of my four weeks, Kathy* (the other Victoria University student) and I bought a card and a box of chocolates for the ward (this was a standard thank you) and we presented these to the NUM at the end of our last shift. Our gift was taken with a gruff “Thanks” as she walked away. Kathy and I were left standing at the desk feeling extremely insignificant and somewhat humiliated. It is moments such as these that I wanted not to pass onto students.

When I became a Registered Nurse I made sure I put my hand up every time we had students. I took the time to get to know them and to be clear on what their objectives for the placement were, working alongside them in a collaborative and positive way. I continued this behaviour in every clinical setting I worked in. After the birth of my first child in 1994 I decided that I would like to become a midwife and enrolled into the inaugural Bachelor of Midwifery once again at Victoria University, graduating in 1995.

At the start of 1997, my husband took on a senior management position on a large pig farm in Young, New South Wales. I had not long given birth to our second daughter and decided to take some time off from work to raise the girls

(at that time, aged 2 years & 7 months); however, this was not meant to be. When Megan was due for her 8 month immunisations, I dutifully went along to the local GP clinic and explained we had just moved to NSW. The doctor asked me if I worked and when I answered, “Yes, I am a midwife” he was very keen for me to work at the hospital as they were desperately short of midwives. I started work the following week, casual at first and within six months on a permanent part-time basis.

I sometimes feel I learnt the most over those five years at that small, rural, local hospital. The diversity of nursing experiences I encountered was remarkable and I loved the variety but there was something missing in my work: I soon realised there were no nursing students involved; the hospital never took students for clinical placement and I missed the resultant lack of interaction with them so I enrolled into a Masters of Education by correspondence through Charles Sturt University.

When I finished my Masters I was keen to apply what I had learnt. Our nearest TAFE was Cootamundra, some 60 km away; they had an EN course and coincidentally were advertising for teachers. I spent 12 months at Cootamundra TAFE learning the basics of classroom management, as well as how to prepare for tutorials and lectures. While the Masters degree had provided me with a solid understanding of theories of learning, evidence based practice and research, I felt the concepts of how to teach this were missing. As a consequence, I enrolled in a Graduate Diploma of Vocational Education and Training. This course set me up with basic principles needed to prepare for and deliver quality training sessions.

Part of the TAFE teaching role involved attending clinical placement with the nursing students during their acute-care rotation. The placement was held at a large tertiary teaching hospital at Wagga Wagga. This was my first experience as a clinical teacher and immediately I could see the relationship void between students and ward nurses. There was little or no interaction between them as the ‘teaching’ was left to the clinical teacher. This prevented the student from becoming part of the team with no sense of belonging. While

they were gaining experience with practising certain skills there was no connection to the reality of nursing. As I was new to teaching, I was not sure how to address this or even if it was an issue as no-one else seemed to be bothered by it; however, the disconnects between theory and practice, and practice and reality, existed and the recollection of these were etched in my mind.

I moved back to Victoria in January 2002 I commenced employment as a TAFE teacher with Victoria University at the Sunbury campus. For the next two years I consolidated my classroom teaching experience giving neither time nor attention to clinical experience.

It was not until I took on the role of Clinical Coordinator of nursing at Victoria University TAFE that I start to give this area of student clinical learning some attention. First, I needed to get my head around the pragmatics of how clinical practice fitted into the curriculum; second, was developing a greater understanding of how to secure quality clinical venues. This was my first realisation that I needed to develop a strong partnership with clinical venues; thus, my role saw me travelling to every clinical venue and meeting with Directors of Nursing, Chief Executive Officers and Clinical Educators.

Building this professional nursing network was vital to the continuation of clinical placements for Victoria University to progress and I was able to secure adequate numbers for our growing student population. With strong external relationships established the next move was to develop stable clinical teachers dedicated to Victoria University. The structure of the Certificate IV (Nursing) course was such that we had students attending year-long clinical placements commencing in January and concluding in December. This meant that, with some forward planning, I was able to secure venues and allocate clinical teachers who needed security of continuous employment. What I found, as an adjunct to this, was that the venues were more satisfied with the clinical teachers. Hospital staff also developed a rapport with the nursing students and started to see them as part of their team. While it appeared that some of the clinical issues were resolved by securing quality placements and increasing

student numbers, I still felt that students were not being introduced to the full gamut of the nursing experience.

At the commencement of 2005 I applied for and was successful in gaining a Lecturer B position with the Higher Education (HE) sector of Victoria University. The transition from TAFE to HE was relatively smooth and within 12 months I was appointed to the position of Year Two coordinator. This was an incredibly challenging role mainly due to the introduction of a new 'enrolled nurse pathway' on successful completion of a four-week summer school, students entered directly into Year Two of the Bachelor of Nursing.

In 2007 the School of Nursing and Midwifery undertook an external audit and complex review of the Clinical Learning Office. Many issues were discovered and nine key recommendations were identified. I was asked to take on the lead role in addressing these recommendations and also took on the role of Academic Advisor: Clinical Learning. During this time I began a systematic review of the issues and commenced implementing strategies to address each of the nine recommendations.

One of these recommendations included securing quality clinical placements. I repeated the process undertaken while at TAFE and began to establish and build partnerships with external providers.

During this time I became aware of alternative clinical models that were being implemented internationally and locally in Queensland. I was granted permission to visit the University and associated hospital in Brisbane who were engaging in an clinical alternative model.. This model was based on the Dedicated Education Unit (DEU) developed by academics Edgecombe, Wotton, Gonda and Mason from Flinders University, South Australia in 1999. As I learnt more about DEUs I began to develop and trial a model based on the Queensland university model that the School of Nursing and Midwifery could adopt.

In March 2008 the first trial of the School of Nursing and Midwifery Pilot (SNMP) commenced at Hospital X * (psuedonym) , a large public hospital in Victoria. The purpose of the SNMP was to educate larger numbers of students

in the undergraduate Bachelor of Nursing, in a more cost efficient way. Anecdotal findings of the SNMP showed the partnership between faculty and nursing staff on the unit was improved and the trial was received positively by Victoria University and Hospital X and as a result, a new trial commenced with Hospital Y *.

On top of achieving its goals to increase numbers and be more cost efficient it was noted that nursing students stated in their evaluations they enjoyed being part of the SNMP. From the evaluations of the SNMP three main themes clearly emerged that were additional to the success of the trial, as follows:

- Flexibility of the model
- Feeling part of the team
- Learning over the semester

It was these three themes that spurred my interest further and I enrolled into the Doctor of Education program at Victoria University, Melbourne Australia, and commenced my research journey to try and answer my question: How can a Flexible Clinical Education Model allow nursing students' learning to be central and valued? The thesis that is now presented documents and evidences my enquiry into this question.

Contents

DECLARATION OF ORIGINALITY.....	I
ACKNOWLEDGEMENTS.....	II
ABSTRACT.....	III
LIST OF PUBLICATIONS AND AWARDS	V
AUTOETHNOGRAPHY	VI
CONTENTS.....	XV
LIST OF FIGURES	XVIII
LIST OF TABLES	XVIII
LIST OF ABBREVIATIONS AND ACRONYMS.....	XIX
CHAPTER 1	1
INTRODUCTION.....	1
Context of the research.....	1
School of Nursing and Midwifery Project (SNMP)	4
The current study.....	7
Gaps in the literature.....	8
Research problems.....	9
Purpose of this study.....	9
Research question.....	10
Key terms	
Significance of the problem.....	10
Theoretical underpinning.....	11
Thesis outline	12
Summary	12
CHAPTER 2	13
LITERATURE REVIEW.....	13
Introduction	13
History of nurse education in Australia.....	14
Clinical education.....	16
Models of Clinical Practice	20
Supervision Model.....	21
Preceptorship model	23
Facilitator model.....	25
Dedicated Education Units	26
Strength of partnerships.....	28
Communities of Practice	32
Communitites of Practice in nursing	38
Communitites of Practice in education.....	39
Communitites of Practice and the Flexible Clinical Education Model.....	41
Best practice clinical learning environment	42
Summary	43

CHAPTER 3	45
METHODOLOGY AND RESEARCH DESIGN	45
Introduction	45
Research Aims	46
Research questions	47
Ethnography	47
Ethnography and nursing	49
Limitations of ethnography	51
Research Design	52
Setting and Participants	53
Students (15 in total).....	54
Clinical ward staff (7 in total).....	55
Academic staff (4 in total)	55
Data collection.....	56
Participant observation	56
Field notes.....	57
Journal entries.....	58
Focus group interviews.....	59
Individual interviews	60
Academic interviews	61
Clinical Ward Staff interviews	61
Ethical considerations.....	61
Potential risks	62
Data analysis	65
Triangulation	65
Focus groups and individual interviews	66
Thematic analysis	66
Limitations	70
Summary	70
CHAPTER 4	72
FINDINGS	72
Introduction	72
Themes.....	73
Emerging themes	74
Preparation	77
Communication	78
Reflective practice	86
Balance.....	90
Commitment	94
Partnership.....	97
Communication	98
Reflective practice	108
Balance	109
Commitment	111
Satisfaction	115
Communication	115
Reflective practice	122
Balance	125
Commitment	127
Sustainability	129
Reflective practice	130
Balance	130
Commitment	132
Summary	132

CHAPTER 5	134
DISCUSSION	134
Introduction	134
Theories of learning.....	134
Best Practice Clinical Learning Environments.....	137
An organisational culture that values learning	138
Best clinical practice.....	141
A positive learning environment	142
A supportive health service-training provider relationship.....	148
Effective communication processes	149
Appropriate resources and facilities	151
Preparation	152
Partnerships.....	153
Satisfaction	155
Sustainability	156
Flexible clinical education models and communities of practice	157
Summary	159
CHAPTER 6	160
CONCLUSION.....	160
Limitations	161
Small sample size	161
Intimidation (researcher as Associate Head of School)	161
One semester	162
Only students in the current flexible clinical education model.....	162
One venue.....	162
Implications	163
New research	163
The Flexible Clinical Education Model.....	164
Recommendations	165
Conclusion.....	166
REFERENCES.....	168
APPENDICES.....	179
Appendix 1 Information for Participants.....	179
Appendix 2 Request to attend orientation	182
Appendix 3 Participant Observation template	183
Appendix 4: Excerpt from transcribed field notes.....	184
Appendix 5 Interview questions for student Focus Groups.....	185
Appendix 6 Interview questions for academic staff	186
Appendix 7: Interview questions for Preceptors	187

List of Figures

Figure 2.1	Communities of Practice and the current study	34
Figure 3.1	Flexible Clinical Education Model	52
Figure 4.1	Inter-relation of themes and enhanced student learning.	74
Figure 4.2	Research question and themes.....	76
Figure 4.3	Communication and student learning.....	78
Figure 5.1	Promoting effective communication.....	154
Figure 6.1	Key elements of a Flexible Clinical Education Model	165

List of Tables

Table 1.1	Financial cost SNM 2007.....	4
Table 1.2	Summary of Hospital X services.....	5
Table 3.1	Participant summary.....	54
Table 3.2	Summary of participant observation	57
Table 3.3	Focus group interview dates.....	60
Table 3.4	Thematic analysis process.....	66
Table 3.5	Example of transcript preparation.....	67
Table 3.6	Example of identifying meaning units	68
Table 3.7	Example of group patterned meaning unit ‘sustainability’	68
Table 3.8	Generated basic theme statements	69
Table 3.9	meaning units	69
Table 3.10	Summary of themes.....	70

List of Abbreviations and Acronyms

ACU	Australian Catholic University
AHPRA	Australian Health Practitioner Regulation Agency
ANF	Australian Nursing Federation
ANMAC	Australian Nursing and Midwifery Accreditation Council
BPCLE	Best Practice Clinical Learning Environments
BN	Bachelor of Nursing
CDNM	Council of Deans of Nursing and Midwifery (Australia and New Zealand)
CF	Clinical Facilitator
CLO	Clinical Learning Office
CoP	Communities of practice
CPN	Clinical Placement Networks
CPS	Commonwealth Supported Places
CUC	Clinical Unit Coordinator
CINAHL	Cumulative Index to Nursing and Allied Health Literature
DEU	Dedicated Education Units
DHS	Department of Human Services
DoE	Department of Education
DoH	Department of Health
EFTSL	Equivalent Full Time Student Load
EN	Enrolled Nurse
EOI	Expression of Interest
HREC	Human Research Ethics Committee
HWA	Health Workforce Australia
IP	Information to Participant form
NHWT	National Health Workforce Taskforce
NUM	Nurse Unit Manager
PO	Participant Observation
RN	Registered Nurses
SNM	School of Nursing and Midwifery
SNMP	School of Nursing and Midwifery Project
UK	United Kingdom
VCPC	Victorian Clinical Placement Council
VU/VUT	Victoria University/Victoria University of Technology

CHAPTER 1

Introduction

Context of the research

As a practice-based profession, clinical placements provide students with the opportunity to experience nursing in the real world. Ideally, they enable students to put theory into practice. Clinical practice is an essential part of an undergraduate nursing curriculum and a requirement for registration with the Australian Health Practitioner Regulation Agency (AHPRA). Clinical practice provides students with an opportunity to achieve competence in safe and effective work practices, and develop the skills, knowledge, attitudes, values and abilities identified in the ANMC National Competency *Standards for the Registered Nurse* (ANMC, 2006).

This chapter provides a background to the existing problems that led to the instigation of this study. It provides a review of the background, the significance of the problem and introduces this study. The chapter also identifies the research area of investigation, research questions in this study alongside key terms and definitions. Theoretical underpinnings are also introduced. The final part of this chapter provides an outline of all the chapters contained in this thesis.

A reduction of nurses over the past 20 years led to an increased demand for student places in the Bachelor of Nursing. In recent years, the Commonwealth Government has responded to current and projected shortages in the national health workforce by dramatically increasing the number of Commonwealth Supported Places (CPSs) in medicine, nursing

and allied health courses (Darcy Associates, 2009). Victoria has successfully campaigned to secure a significant proportion of these places and as a result, has seen a substantial growth in the number of CSPs allocated to its undergraduate health courses. The increase is necessary to provide the pipeline of health professional graduates required in Victoria over the next two decades. However, the increase in student numbers represents a significant additional toll on an already over-burdened health service sector. In addition, higher student numbers has increased the burden on clinical venues, where there was already a shortage of clinical placements (National Health Workforce Taskforce (NHWT), 2009). The increase in the number of nursing students coupled with an increased number of new graduates in the system has led to further challenges in securing quality undergraduate clinical placements.

As a practice-based profession, clinical education is an essential part of the undergraduate nursing curriculum. Elliot (2002) claims that clinical placements provide students with the opportunity to experience nursing in the real world whereby students can place theory into practice. In order to inquire into a means of increasing student numbers, during semester one 2008, the researcher conducted a study with Victoria University's school of Nursing and Midwifery (SNM) and Hospital X. The study aimed to look at new models of clinical practice. In particular this project focused on introducing a different model of clinical education, based on the dedicated education units (DEU) first established by a group of academics at Flinders University, Australia (Edgecombe, Wotton, Gonda & Mason, 1999). There was a need for alternative models to be trialled, as the traditional clinical placement model generally followed a Monday to Friday 'block' model, which had several disadvantages. For example some of these disadvantages include, limitation to morning shifts only, not student focused, limitation on student numbers and high cost associated with appointing clinical teachers.

Since the transfer of nursing education into the higher education sector, clinical learning has predominantly concentrated on morning shifts. The

learning experience has been limited to times when clinical venues are well resourced, decreasing the opportunity for students to experience the nature and challenges of nursing during a night shift or over a weekend.

The traditional block model did not follow adult learning principles and offered only short bursts of learning using a rigid format. Waters (2008) conducted a large study and contacted all universities in the United Kingdom that taught nursing courses between 2002 and 2006. The Freedom of Information Act was used to discover how many students began three-year pre-registration courses in 2003, and how many completed in 2006. A total attrition rate of 26.3 per cent was seen (p 12). Waters (2008) asserted one of the key factors to this high attrition rate was that students found it difficult to balance course demands with other commitments, such as family and part time employment.

One of the most significant disadvantages of the traditional model was that it limited student placement numbers. A ratio of 1:8 existed, meaning one clinical teacher was required to provide supervision to a maximum of eight students. Some venues even stipulated a ratio of 1:6 making clinical placements even less cost effective. High clinical teacher costs increased when students were absent or simply failed to show for placement. Costs for clinical education at Victoria University was higher than all academic staff salaries (permanent and casual) and can be seen in Table 1.1.

Expenditure	2007
Salaries	
Academic Sessional	\$429,820
Academic on Costs	\$70,275
Total Salaries	\$500,095
Practicum Expenses	
Clinical Practicum: Agencies	\$343,206
Clinical Practicum: Hospitals	\$398,436
Total Practicum	\$741,642

TABLE 1.1 FINANCIAL COST SNM 2007

Overall the School of Nursing and Midwifery could see that the traditional block model was not cost effective and alternative models needed to be investigated further.

School of Nursing and Midwifery Project (SNMP)

As noted above, the increase in student places put immense pressure on the already limited available clinical places in the health care sector. There soon evolved a need for alternative clinical models so as to address this issue. This led to the development of an innovative model trialled as a collaborative project between Victoria University and Hospital X during semester one, 2008. This project had a similar title to the current study and to ensure the reader is aware of each model, the project in 2008 will be referred to as the ‘School of Nursing and Midwifery Project’ (SNMP) and the current study for this thesis will be referred to as the ‘Flexible Clinical Education Model’. It is imperative that the reader understands the background that led to the initiation of the Flexible Clinical Education Model, because it was the findings from the SNMP that triggered the need for further investigation into partnerships and enhanced student learning.

As mentioned in the autoethnography (pg x111) In September 2007, the School of Nursing and Midwifery first introduced the notion of a flexible clinical model that had been trialled at a large public hospital by another university in Queensland, Australia.. Prior to the commencement of the SNMP, numerous meetings were held between the researcher, NUM, clinical facilitator (CF) and associate nursing unit managers (ANUMs) at Hospital X.

Hospital X is a combined health service covering Melbourne and is a major public provider of acute health services. Hospital X provides a range of health services including emergency, elective, medical, surgical, obstetrics, paediatrics, community-based rehabilitation, acute geriatric medicine and subacute services from three acute hospital campuses. In addition, Hospital X delivers residential aged care services and drug and alcohol services. Table 1.2 provides an overview of the services available at each Hospital X venue.

All research for the SNMP was conducted at Hospital X. A total of 15 meetings occurred between the researcher and Hospital X staff and a total of three meetings were conducted between the researcher and undergraduate nursing students participating in the inaugural SNMP. These meetings ensured the implementation of the SNMP was smooth, uneventful and that staff were well prepared

Hospital X	Campus a	Campus b	Campus c	Campus d	Campus e
Provides a large range of inpatient and outpatient services including; <ul style="list-style-type: none"> • Acute and sub-acute inpatients • Chemotherapy • Coronary care • Emergency department. 	Centre for Women's and Children's services including; <ul style="list-style-type: none"> • Maternity • Paediatric • Acute • Sub-acute • Emergency department 	Smaller hospital with services including; <ul style="list-style-type: none"> • Aged Care including geriatric care and evaluation • Community Based Rehabilitation • Emergency Department 	A residential aged care facility, which provides high care services to frail people referred by the Aged Care Assessment Service.	Located only a short distance from campus b that provides some hospital services are.	Provides a diverse range of services and programs for individuals and their families affected by drug and alcohol related problems.

TABLE 1.2 SUMMARY OF HOSPITAL X SERVICES

The SNMP was trialled to improve access and capacity in the health care system, as it was necessary to consider a broader range of innovative ways that clinical education could be delivered. All second year nursing students were invited to participate and expressions of interest (EOI) were requested. A total of 35 students submitted an EOI; after the first introductory session, 30 commenced the trial. Over a sixteen week period the nursing students were required to complete 70 hours clinical practice following a flexible roster that included three shifts (morning, evening and night duty) and was available over seven days including weekends. On Monday 17 March 2008, Victoria University and Hospital X commenced the innovative project of an alternative clinical model. Ward 2 (Neuroscience) was the ward where the SNMP was to be run. During the implementation of the SNMP trial, the researcher attended ward 2 on a weekly basis to visit students and discuss any issues or concerns with the CF, NUM or clinical ward staff.

The objectives of the SNMP were to increase student placement numbers and to reduce clinical teacher costs. Both objectives were achieved, with 15 extra shifts per week available for students and a reduction in clinical teacher costs by up to 44%. However, it was the comments from the questionnaires that triggered interest and spurred the need for further investigation to the student learning experience.

A survey instrument was developed for the SNMP. The survey consisted of eleven questions using a five point Likert scale and three open ended questions. Data was analysed and presented as a review of the SNMP. Nine staff members and 26 students completed the evaluation and the overall response was positive. Overall, students commented they enjoyed the experience of the SNMP. The flexibility suited most students with a general consensus that the SNMP made juggling work, clinical, university and family commitments easier.

The anecdotal evidence that emerged suggested that the SNMP was an optimal teaching/learning environment through the collaborative efforts of

nurses, management and faculty. The findings from the SNMP were such that the model was put forth as an exemplary innovative model and received a place in the top thirteen examples of innovation in teaching and learning at Victoria University (Aitkin & Mitchell, 2008).

While the Bachelor of Nursing already comprises 43% learning in the workplace (SNM curriculum, 2009), it seemed the SNMP allowed students to become encultured in the nursing environment. Being part of the nursing team, students commented they gained a rich experience from expert clinicians as they performed in their role as nurses. The positive anecdotal findings led to the realisation that a further study was required to explore the clinical learning experience of students and the development of a partnership between academics and clinical agencies.

Further research was carried out by the researcher and it became clear that the literature is inconclusive about the relative advantages of any one clinical education model. However, it is clear that models provide quality learning environments where they involve genuine partnerships between clinical agencies and the university, where student learning is central and valued and where academics and clinicians are well prepared to meet the objectives of student placements. A thorough review of the literature on models of clinical learning is presented in chapter two, the following now continues with the current study.

The current study

Incidental evidence gleaned from the SNMP led to the investigation of the current study. Wellard, Williams and Bethune, (2000) testify there is little published evidence demonstrating the effectiveness of any one model of clinical facilitation, or that any particular model is better than any other in achieving quality outcomes. Although a significant amount of research has been undertaken in reviewing clinical learning environments, including many articles investigating students and teachers, perceptions of these environments

(Chan, 2004; Lee, Cholowski & Williams, 2002), very little emphasis has been placed on creating or suggesting a model for best practice. Researchers like Chan and Ip (2007) have placed emphasis on identifying and addressing poorly perceived aspects of environments. In doing so they have aligned student and teacher perceptions or have focused on specific teaching modalities (Lee et al., 2002), rather than defining the composition of a best practice environment. Where models have been proposed, these tend to be a set of minimum standards, developed by hospitals or training organisations, as opposed to frameworks aimed at achieving an optimal level of educational experience Darcy (2009).

This study explored the qualities of a partnership between academics, students and nursing staff and looked at student attitudes and learning during the Flexible Clinical Education Model. As described previously in the autoethnography section the interest in conducting this study arose from the researcher's experience as an academic and in her observing the frustration, and often distress, that clinical placement caused students and staff (academic and clinical). To investigate effective models of practice that would enrich the teaching and learning experience of all stakeholders involved in practicum settings was therefore a central aim of this work.

Gaps in the literature

Since the move from hospital-based training to the higher education sector, most studies on clinical nursing education recommend that further research is needed to develop innovative models of clinical learning and to test clinical learning models and clinical placement structures for their impact upon clinical learning. At the time of this study there was little evidence to support any one model. Most recently, Franklin (2013) undertook an extensive literature review of the five clinical supervision models described by Health Workforce Australia (HWA). Her research demonstrated there is clear evidence to support facilitator-preceptor and dedicated education unit models as the two models of clinical supervision to best support a clinical learning environment.

Research problems

Connecting textbook descriptions of clinical situations with the reality of practice is a continuous problem for the nursing profession. Scully (2011) maintains this is referred to this as the “theory-practice gap” (p93). Further, Spouse (2001) claims this universal gap is encountered by most nurses at various times where student nurses often find themselves in the midst of the theory-practice void. However, it is not just students who are affected by the theory-practice gap. Gardiner, Rolfe and Ghroum (2013) contend clinical ward staff believe that academics have lost touch with the real clinical environment. In contrast Watson and Thompson (2008) assert academic staff believe clinical staff are not research active and do not provide evidence-based care. Such a dichotomy leads to allegations that students are deemed to be not practice ready on completion of the Bachelor of Nursing (Wolff, Pesut, Regan 2010). This separation of theory and practice often makes students comment they feel like visitors (Levett-Jones, Lathlean, Higgins & McMillan, 2009) and are hesitant to provide impromptu care. Dunn and Hansford (1996) elaborate that students often feel like a burden or hindrance to ward staff. A clinical model whereby academic and clinical staff work together to provide a safe learning environment, to best educate undergraduate nursing students, is therefore necessary and warranted.

Purpose of this study

The purpose of this study is to produce a clinical model that provides undergraduate nursing students with an optimal learning experience. A model that capitalises on the expertise of both clinicians and faculty. A model that includes communities of practice where tacit knowledge can be harnessed and enhanced through strong partnerships. Previous researchers (Edgecombe et al., 1999; Ransie & Grealish, 2007; Wotton & Gonda, 2004) suggest that a flexible model of clinical education will provide students with a positive clinical learning environment that maximises the achievement of student learning outcomes. Edgecombe et al.’s (1999) dedicated education unit, a clinical

placement model developed through a strategic collaboration between clinicians and academics, showed positive outcomes in students' transfer of theory into practice. Further, a flexible model is believed to enable students to work alongside expert clinicians, while at the same time offering opportunities to expose students to the experiences of weekend and after hour work.

Essentially, the purpose of this study is to achieve a deeper understanding of what constitutes quality clinical education from both students' and practitioners' perspectives. Through giving voice to the lived experiences of a range of nursing stakeholders, the researcher is in a better position to provide insight into elements that lead to better educational outcomes. Further, drawing attention to the challenges and benefits of this flexible model will add value to nursing education and future research through exploring alternative avenues that enhance student and practitioner experiences of clinical practice.

Research question

The overarching research question for this study is 'How can a Flexible Clinical Education Model enable nursing student learning to be central and valued?'

Key terms

The following key terms express the underpinning characteristics of the Flexible Clinical Education Model:

Building partnerships, enhancing learning, belonging and promoting value and respect.

Significance of the problem

This study considered partnerships between academics and clinical agencies, and observed student learning in a clinical environment. Understanding how academics and clinicians are best prepared to meet the objectives of student

placements provided nursing students with satisfaction in their clinical experience and ultimately may provide patients with optimal care and treatment.

This study was vital to investigate the provision of a quality clinical experience to undergraduate nursing students at Victoria University. It also aimed to enquire into elements and characteristics that contributed to a cohesive partnership between academics and ward staff. This study aimed to establish further that a model of flexible clinical learning may provide a variety of positive effects. Further, with a focus on encouraging academics, students and clinicians to integrate theory introduced in the university, this study aimed to examine students learning experiences within the clinical environment.

The value of this study lies in the expected implications for nursing education and future research. A better understanding of what constitutes quality clinical education from a student perspective is valuable in providing better educational experiences. It is hoped through the presentation of findings from this study that a flexible model of clinical education can be incorporated in the undergraduate nursing curriculum at Victoria University.

Theoretical underpinning

The Flexible Clinical Education Model is informed by Wenger's (1998) social theory of learning known as 'communities of practice' (CoP) theory. Engagement and participation in the clinical workplace are essential for nursing students and communities of practice provides a framework to understand the ways students learn and identify as nurses in clinical placements. Strategies to support learning in the workplace can be shared between students and clinicians as nursing students engage in the workplace, through practices of participation and non-participation.

The model enables nursing students to have extended exposure to learning in the clinical environment. Theoretically, using the premise of

social learning, students in the Flexible Clinical Education Model are exposed to a culture of learning by observing and working under the guidance of experienced nurses. The model purports to allow nursing students to be active constructors of their own learning, a central view of learning in the communities of practice framework.

Thesis outline

Chapter One provides an overview of the background and significance of the study. It introduces the theoretical underpinnings of the study and provides a prologue to the School of Nursing & Midwifery Project that informed the inception of this study. Chapter Two provides a detailed review of the literature. Chapter Three, presents the research design and methods used to measure and explore academics, clinical staff and nursing students' experiences of the Flexible Clinical Education Model. This is followed by the findings chapter (Chapter Four) where the findings from this study are presented under each research question. Chapter five, provides a detailed discussion of the findings from the qualitative data analysis. These data are interpreted and converged to better understand the experience of the Flexible Clinical Education Model and its implications for students, academics and the nursing profession. Chapter Six presents the recommendations for practice and concludes the thesis.

Summary

In summary, Chapter One provided a detailed overview of the SNMP that informed this study, and included the background to the existing problem leading to the instigation of this study. It provided a review of the problem's significance, and introduced the study's purpose. The research problems and overarching research question were identified in this chapter, and the key terms and definitions provided. The final part of this chapter provided an outline of all the chapters contained in this thesis.

CHAPTER 2

Literature Review

Introduction

In Chapter 2 a review of the literature related to clinical education for undergraduate nursing students is presented. The main strategy used to identify relevant literature included searching the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline and ERIC databases, using a number of key words developed in consultation with the health librarian at the Victoria University library. These included (but were not limited to) clinical education, clinical supervision, clinical learning, clinical learning environment, nurses' education, partnerships, communities of practice and best practice clinical learning environment (BPCLE). Additional information sources such as reports, projects and theses were also identified and accessed.

This chapter begins with a brief overview of the history of nursing in Australia, including background issues related to nursing education's move into the tertiary sector. This is followed by a discussion of clinical education within undergraduate nursing programs and the challenges faced by students when they are on clinical placement. The literature review then addresses three key models of clinical practice: a supervision model, a preceptorship model and Dedicated Education Units (DEU). An overview of how partnerships provide an opportunity for innovative practice in clinical learning environments is presented. In addition, the importance and role of communities of practices, principles of adult learning and the role of communities of practices in the Flexible Clinical Education Model are

examined. The chapter then concludes with a brief summary of the key points discussed in this section.

History of nurse education in Australia

Nursing requires a combination of technical skills, clinical experience and theoretical knowledge. Historically, there has been a tendency for nursing education to focus on attaining nursing skills; however, nursing practice is far more complex than technical skills alone. Nursing expertise is required for interpreting clinical situations and for complex decision making: it is the basis for the advancement of nursing practice and the development of nursing science. When providing nursing care, nurses make clinical judgments about the care needed for clients based on evidence, experience and standards of care.

The history of nurse education in Australia is inextricably linked to the country's penal history. In the establishment of the original English colony at Sydney Cove, little attention was paid to the provision of care for the ill and infirm; founding the colony was the priority. When Sydney Hospital was opened in 1811, most nurses were convict women with some convict men also performing nursing duties. Nursing staff during this era were provided with their keep but were given no wages in exchange for their labour (Daniels, 1998). However, one woman, Florence Nightingale, altered the status of nursing from that of domestic service to that of a vocation (Nightingale, 1893/1949; Nightingale, 1895).

Florence Nightingale used her intellect and the strength of her own character to create a permanent professional transformation (Bostridge, 2008; Dossey, 2000). Nurses were trained in practical skills, such as the application of dressings, leeching and administering enemas. Of equal importance were the character traits of punctuality, cleanliness, sexual purity and, above all, obedience (Wellman, 1999). When Lucy Osburn and her four Nightingale-trained nurses arrived in Australia in 1868, the 'Nightingale influence' was

experienced for the first time. Gradually, the Nightingale principles for care of the physically ill were adopted (Wellman, 1999).

Greenwood (2000) in his international critique of graduate nurses explored pressures which underpin nurse education and suggests it was widely accepted that nurses trained under the Nightingale model were doers rather than thinkers. Greenwood elaborates by attributing this to their socialisation into authoritarian nursing culture with the historically dominant role of the doctor and subservient role of the nurse. This relationship continued to be reinforced by gender, education, and remuneration. As scientific advances were made, the recognition of a need for a more formal nursing training grew. By 1900, most of the larger Australian hospitals had three-year training programs for student nurses. Prior to the Sax Report (Sax, 1978), nursing was based on a traditional apprenticeship model of training. However, it was generally recognised that this system was failing to equip nurses with the skills required for health care provision into the 1980/90s and beyond (Greenwood, 2000). The Sax Report noted that the apprenticeship system of nursing education was producing nurses who had a narrow view on health and went on to suggest nurses were opposed to change and unable to manage scientific and technical advances in medicine (Sax, 1978). This was not the first time this had been noted, with similar issues raised in the earlier Briggs Report (1972) in the United Kingdom (UK). Consequently, arguments were put forward to support the move of nursing education into the higher education sector. In 1984, the Federal Government announced its full support for the transfer of nursing education to the tertiary sector. This occurred over the subsequent decade (Australian Nursing Federation (ANF), 2007).

With nursing education now in the higher education sector, it was recognised as a profession and discipline in its own right. This was partly achieved not only with the move of nursing study into the tertiary sector, but also because the profession has launched itself into the research arena, with knowledge, expertise and lifelong learning gained through a continual process of critical thinking (Greenwood, 2000; Kaufman, 2003). The move

into tertiary education established research productivity with more explicit emphasis on critical thinking, decision making and evidence-based approaches to practice. Thus, an important shift occurred that arguably aimed to produce quality graduates practically prepared for complex skills and procedures, while moving towards preparing graduates who can apply problem solving and clinical decision making to real patient situations.

Clinical education

Heath (2002) contends that clinical education for a practice discipline such as nursing is an integral and essential component. Whereas university programs may prepare students with skills in laboratory situations, Ogle, Bethune, Nugent & Walker (2002) claim it is the immersion in clinical settings that is essential to nurses' understanding of the profession. No one disputes that clinical education is not a fundamental component of an undergraduate nursing degree; however, the quantity remains contentious. The Ogle team (Ogle et al., 2002, p. 59) provides comparative information about the amount of clinical experience offered in undergraduate nursing programs and concludes that most universities require students to spend 'between 600 and 1100 hours' in clinical placements.

When preparing undergraduate nursing students for practice, Hoge, Huey & O'Connell (2004) suggest clinical practice performance and competency assessment are also contentious, particularly in relation to readiness for graduate practice. Hoge et al. (20014) claim there is growing concern about the quality of healthcare in America, accompanied by calls for improvement in the quality of care. Further, Hoge et al. contends that undergraduate nursing students are expected to develop clinical knowledge, skills and attitudes for professional practice. Recently, Cant, McKenna & Cooper (2013) have questioned the objectivity and parity of students' clinical assessments.

Greenwood (2000) attests that the first three to six months of new graduates first year as a registered nurses is the most critical time for professional adjustment. Goh & Watt (2003) provide evidence that new graduates find their transition to graduate practice very stressful and demanding and suggest there is an increasing pressure to perform immediately at a high level by their work colleagues. Although initially feeling pressured, new graduates complete this transition successfully, with marked improvement in performance in the first year (Dunn & Hansforth, 1996).

Considering the complexity and diversity of health care and current worldwide workforce issues, registered nurses are generally well prepared for graduate practice, with good overall competence (Department of Human Services, 2005). Other issues such as financial constraints, clinical placement availability, length and timing of clinical placements and models of clinical learning have been identified and are discussed in detail below.

All clinical education arrangements are heavily dependent on collaborative structures and policies in the education and service sectors. Core funding for undergraduate university courses comes from a combination of Commonwealth Government and domestic student contributions, supplemented by fees from international students (Health Workforce Australia, 2011). The base funding rates do notionally include components relating to clinical training. In 2008, there were some adjustments made to increase funding to areas of skills required, which saw an increase ranging from \$2,729 per Equivalent Full Time Student Load (clinical psychology) to \$109 (nursing); these increases, as pointed out here, were relatively modest for nursing faculties (HWA, 2011). This low-level of support for nursing was raised in the Bradley Review (Discussion Paper 2008, p. 166) where it was noted that in terms of financial assistance for clinical placements, 'the levels of Commonwealth funding provided for clinical nursing placements fall short of the actual cost of provision'. Based on the findings of the Council of Deans of Nursing & Midwifery Australia &

New Zealand project (Council of Deans of Nursing & Midwifery Australia, 2011), the average cost of coordinating and providing clinical supervision to pre-registration nursing students, for the minimum 800 hours of clinical placement over three years, was \$6,672 or \$8.34/student/hr in 2010. Costs were as high as \$9048 (\$11.31/student/hr) in some universities (Council of Deans of Nursing & Midwifery Australia, 2011, p. 5). With increasing costs to the clinical setting there evolve challenges around securing quality clinical placements that are sustainable in the Bachelor of Nursing budget.

With knowledge of these figures, many universities argue they are reluctant to pursue further growth in nursing if the current funding model remains in place, especially given the rising cost of securing appropriate clinical placements (HWA, 2011). Barnett et al. (2008) declares the current nursing workforce crisis commands that tertiary providers increase the number of graduates from nursing courses. Victoria University has targeted its nursing programs as requiring growth in student numbers. Since 2008, undergraduate nursing student numbers at Victoria University have remained stagnant. This has resulted in a desire to put into place long-term strategies that can ensure greater access to clinical placements for undergraduate nursing students (Blatch, 2013). Recognition that there is conflict between the external financial constraints placed on nursing and the university's requirement to increase undergraduate nursing places, results in the need to put into place a more cost efficient clinical model.

In times of financial constraint, nursing workforce shortages and professional change, collaboration between universities and industry is challenging. For example, the completion of supervised practice in health service settings is an essential element of an undergraduate nurse's preparation and a measure of competent entry-level. This places extra pressure on course coordinators to ensure sufficient clinical placements are available for health students who plan to work as practitioners in Victoria. The Department of Health (2011) considers that ensuring quality abundant clinical placements is a key step in securing a reliable supply of a competent

and adequately-sized workforce that meets community health and social care needs.

At present, the Department of Health Victoria, in partnership with Health Workforce Australia, have introduced a number of initiatives, including funded projects aimed at increasing capacity for clinical education. These initiatives of institutional collaboration have assisted with the availability of clinical placements for students in the medical/nursing/health sphere. The projects were administered by the Victorian Clinical Placement Council, through eleven clinical placement networks (CPNs). The introduction of CPNs provided effective coordination and continued commitment to capacity building and quality improvement of clinical learning environments. However, this does not address the topic of how many clinical hours undergraduate nursing students require.

Providing students of pre-registration nursing programs with appropriate clinical experience during their preparation programme is critical. According to Cant, McKenna & Cooper (2013), clinical placements ensure graduates can meet the competency standards required for registration as a registered nurse and are adequately prepared for transition to the workforce. It is also a requirement for course accreditation under the Australian Nursing and Midwifery Accreditation Council (ANMAC) standards. In order to meet accreditation standards, ANMAC has determined that courses leading to nursing registration must provide at least 800 hours of clinical practice (professional experience) across pre-registration nursing programs (ANMAC, 2009). The 800 hours are a minimum requirement, forcing universities to embrace innovative models of clinical practice while meeting the financial constraints imposed upon them. For Victoria University, this meant the piloting of a new flexible clinical model, the School of Nursing and Midwifery Project (SNMP), during semester one 2008.

The primary aim of the SNMP was to increase clinical placements while decreasing cost and was discussed in Chapter 1. While the general concept of clinical education is underpinned by sound educational principles, the actual

activities in which students engage in this environment may be poorly aligned with those principles. This next section provides the reader with an overview of current literature on models of clinical learning.

Models of Clinical Practice

The clinical education component for undergraduate nursing students has received much attention in recent years. At a university in Sweden, a model of group supervision was included in the baccalaureate nursing programme, conducted by nurse academics (Lambert & Glacken, 2005). The purpose of Lambert & Glacken's study was to explain the worth of clinical group supervision to nursing students, as viewed by nurse academics. Data consisted of field notes written by the nurse academics after 60 supervision sessions, and qualitative content analysis was performed. The findings demonstrated how reflection in a group was found to give nursing students opportunities to increase their understanding of themselves and others. This reflection prepared them for upcoming events, increased their personal and professional strengths, and inspired them for further development.

In Australia, a clinical educator is a Registered Nurse who provides supervision of nursing students. This person can be employed by either a university or a hospital. In turn, each clinical venue will have a particular preference regarding the clinical education model to support students on placement. A major factor in deciding which clinical model is used, includes the partnership arrangements between the health care facility and university. More importantly, it includes the skill mix of the nursing staff available at the health care facility participating in clinical supervision. Richardson, Fentiman, Nash, Lemcke & Varkararawa (2000) claim traditional supervision of nursing students has been undertaken through a standard supervision model with clinical educators. While clinical practice is recognised as the core of nursing education, it is constrained by financial resourcing, funding irregularities and a lack of recognition for nurses involved in clinical

teaching (Clare, Brown, Edwards & White, 2003;; Lindgren & Athlin, 2010; NHWT, 2008; Papp, Markkanen & von Bonsdorff, 2003; Smedley & Morey, 2010). (Clare et al., 2003).

More recently, there has been a move to a preceptor and facilitator models. However, with the increased demand for more nursing places, Dedicated Education Units have emerged (Edgecombe et al., 1999).

Early literature was inconclusive about the relative advantages of any one clinical education model. Early work by Edgecombe, Wotton, Gonda & Mason (1999) claim quality clinical learning exists where academics and clinicians are well prepared to meet the objectives of student placements, and where patients are provided with optimal care and treatment. This was further supported by Kruger, Davies, Eckersley, Newell & Cherednichenko (2009) in the context of teacher education, who maintain clinical models clearly provide quality learning environments where they involve genuine partnerships between clinical agencies and the university and where student learning is central and valued. Contemporary research by Franklin (2013), however, clearly identifies the Dedicated Education Unit (DEU) model as being more advantageous. According to Franklins' findings, the DEU model provides support for students in the clinical environment by fostering critical thinking through reflective practice. The following is a discussion of the three previously most accepted models of clinical education, commencing with the supervision model and followed by the preceptorship model, facilitators model and concludes with the preferred DEU model.

Supervision Model

The supervision model provides undergraduate students with the opportunity to attend a clinical venue for a continuous period, usually from Monday through to Friday. In a study by McKenna & Wellard (2004), the supervision model was found to involve a clinical teacher working directly with a group of students in a clinical setting; the length of time depended on the experience required. For example, a first year placement might be in a subacute setting

such as aged care or rehabilitation centre for three weeks and a third year placement may spend six weeks in an acute area such as a surgical ward. A clinical teacher is allocated to each block and may be employed by the university on a casual basis. In addition, teachers often engage in assessment of up to eight students at any given time. Although this model is seemingly sound from an educational perspective, Nehls, Rather & Guyette (1997) claim it has serious limitations, particularly from the perspective of nursing students having a lack of familiarity with the clinical environment, and in some cases, a lack of knowledge of the clinical specialty that makes up the student's learning space. For example, a clinical teacher whose expertise is cardiac nursing may be responsible for a group of students who are placed on a renal ward, potentially diminishing the student's learning opportunity through a lack of experience. Generally, according to Wellard, et al. (2000), an Australian clinical teacher is responsible for the supervision of eight students. However, this may vary slightly across institutions, depending on the particular clinical focus of the experience or agency preference). Wellard et al. (2000) report that the maintenance of fixed clinical teacher to student ratios has been a cost effective measure for optimising the clinical budget within nursing schools. They state this is because a standard rate of pay can be included in the budgetary process of nursing schools. The more students a clinical teacher is responsible for, the more cost effective the model. In an effort to reduce the cost of clinical teachers, venues and universities often agree on a pro rata rate. Williams, Wellard & Bethune (2001) report this works particularly well in small clinical agencies where eight students cannot be accommodated, and a clinical teacher's working hours accordingly are reduced. This reduction assists with maintaining an acceptable overall cost per student for the length of the placement.

The provision of appropriate supervision of nursing students relates also to quality education for supervisors and is not unique to Australia. For example in Finland, Haggman-Laitila, Elina, Riitta, Kirsi & Leena (2001) acknowledged the selection process for supervisors was not systematic and

realised that increased education was needed. Haggman-Laitila and team undertook a qualitative, triphasic study to develop a model for clinical supervision to promote the clinical practice of undergraduate nursing students. Haggman-Laitila et al. (2001) found that their model enhanced the ‘understanding of health care organisations and nursing education of clinical supervision...’ (pg390). Similarly in the Sultanate of Oman, Madhavanprabhakaran, Shukri, Hayudini and Narayanan (2013) claim that clinical supervisors must have teaching characteristics such as ‘professional knowledge, role modeling and clinical competence with communication skills to facilitate optimal learning’ (pg38). The clinical supervision of nursing students is an international and mutual challenge to health care organisations and nursing education and further models such as the preceptorship and facilitator model have been arisen

Preceptorship model

A preceptor is a registered nurse employed by the clinical venue. This is generally a 1:1 arrangement (one preceptor for one student) with support from a health care facility education coordinator, and/or a university-based academic. Bonreuf & Haigh (2010) suggest, however, that the demands placed on preceptors by an increasingly demanding patient load and limited resources make assessment problematic in practice. They point out the need to balance the assessment process with care delivery and its associated duties as the continuity of the student assessment process is often interrupted and is not viewed as a priority. In addition to this complexity, McCarthy & Murphy (2007) found that the majority of preceptors are inexperienced and do not fully comprehend the student assessment process. They revealed many preceptors focus on the student’s practical skills rather than on the holistic care of patients. McCarthy & Murphy (2007) concluded that the preparation of preceptors was inadequate given the complexity of the clinical assessment process and placed unintentional stress on them.

Academics from the University of Alberta, Canada, Yonge, Krahn, Trojan, Reid & Hasse (2002) claim that the role of a preceptor can be stressful. They conducted a quantitative project to examine the preceptor's' view of their role in supporting students. They revealed that most of their respondents had experienced a significant amount of stress while working as a preceptor. The factors that contributed to stress included the following: a sense of additional responsibilities; insufficient time when the ward was busy; responsibility for student actions. They noted that managers, during busy times, unintentionally added to preceptors' workloads without realising that students already had additional needs that they had to meet. While agreeing with Yonge, et al. (2002) that preceptors found supervising undergraduate nursing students to be at times stressful, Courtney-Pratt, FitzGerald, Ford, Marsden & Marlow (2011) assert that a positive culture of respect and support occurs when a collaborative ward approach to the preceptor/student relationship includes 'welcoming; negotiation of teaching and learning opportunities; and feedback' (pg. 1387).

Myrick & Yonge (2002) believe that preceptors have an important role in the development and promotion of critical thinking in their students; however, they point out that there needs to be a structure in place to ensure that effective learning occurs. It is vital, they suggest, to have a process where student learning needs can be individually addressed; they observe that not all students will have the same learning objectives and it is therefore unrealistic to expect them to complete the same learning activities. Most recently, these issues have been noted by Andersson, Danielsson, Hov & Athlin (2013) who have found that preceptors still struggle with understanding the required knowledge, skills and appropriate clinical teaching strategies for each student's year level within each university's curriculum. They point out that there is a duty of care on the part of the education and industry providers to ensure that students acquire the skills relevant for their year level.

In the earlier work of Grant, Ives, Raybound & O'Shea (1996) they note that preceptors face the unenviable and difficult task of supervising groups of students from a number of universities and for varied placements throughout any particular semester. Shah & Pennypaker (1992) agree that during these placements there is often little support or formal identification of university requirements provided by academics. Grant et al. (1996) continue that preceptors were immersed in day-to-day patient care, resulting in a master-apprenticeship relationship with students, rather than a collegial relationship. Not only is this situation unlikely to assist the transfer of theory to practice, but it also remains problematic for both preceptors and students. To help overcome this situation Nehls, et al. (1997) observed that hospitals have attempted to overcome this by appointing one of their own staff as a preceptor specifically dedicated to the role of educating nursing students – thus releasing them from patient care duties.

Facilitator model

A facilitator model to improve the placement experience for undergraduate students in mental health nursing was investigated by O'Brien, Buxton & Gillies (2008). These researchers conducted a pre-placement-post-placement survey, the results of which demonstrated the facilitator model helped to increase student interest in mental health nursing. Their study of 257 undergraduate nursing students and 12 registered nurses highlights that the facilitator model of clinical supervision was preferred by students when facilitators were registered nurses employed by the health care provider and were seconded specifically to facilitate undergraduate nursing students. This was seen as advantageous by the undergraduate nursing students. The students viewed their facilitators as role models and could draw upon the registered nurses knowledge of the clinical venue, as well as their practical skills. Furthermore, they noted that the facilitator model was viewed favourably by the registered nurses. One major reason for this was that when registered nurses were in the role of a facilitator, they were able to concentrate solely on

student clinical learning objectives without having to juggle patient care and the added pressure of preceptoring students. At the same time, these registered nurses viewed facilitating undergraduate nursing students as an opportunity to further professional development by undertaking clinical facilitation.

In their review of the literature in the area of clinical facilitation, Lambert and Glacken (2005) emphasise the lack of role clarity with the clinical facilitator job title. The literature reviewed highlights challenges in defining the role, delineating its boundaries and in distinguishing the term facilitation from similar and overlapping concepts such as supervision, mentorship and preceptorship.

Until recently there has been no consensus about a preferred model for clinical placement or approaches that best deal with the constraints of funding; nevertheless Clare et al. (2003) contended that a way forward lay in cooperative, joint strategies between the education and clinical sectors. They acknowledged that combining the positive aspects of each clinical model can create new and improved models of clinical learning. It is such acknowledgement, according to Wotton & Gonda (2004) that led to the emergence of the dedicated education unit.

Dedicated Education Units

Dedicated Education Unit's (DEUs) were developed in the late 1990s by nursing lecturers at Flinders University, Adelaide, in response to a call for greater collaboration between clinicians and academics involved in clinical nursing education (Wotton & Gonda, 2004). The drive to establish DEUs for undergraduate nursing students was based on anecdotal evidence from students and the emerging data on quality literature. A DEU's foundational philosophy, according to Wotton & Gonda (2004), is to develop sound relationships between clinicians and academics, to respect and value their contributions towards establishing the best clinical learning environment for nursing students, and to value those students' opinions about that environment's quality.

Each DEU is determined by the context of the clinical learning opportunities available that include, acute medical and surgical areas, community service organisations such as mental health. Thus, a DEU may be set up in a 32 bed acute medical ward or in a community based centre. Each semester there may be a number of first, second and third year students in the ward, with two or three from each year level on shift together. Students may be on the ward for two days per week over a 16-week period, compared with a traditional block placement of three or six weeks' full time. The extended placement duration allows students more time for reflection, enabling a greater input into what and how they learn. The extended duration supports the principles of adult learning identified by Brundage (1980, p. 5) that adults 'transform (modify, relearn, update and replace) knowledge, skills, strategies and values through experience'.

Edgecombe et al. (1999) developed DEU's dedicated to the clinical education of students. As a background for their study the authors clearly highlighted the need to address student clinical learning outcomes. The evidence presented in their study supported their opinion that there was a need to improve the current student experience. The main weakness of their study, however, was that it occurred at the time nursing was changing from hospital-based 'training' to university sector formal education. This move was not educationally supported by all researchers; according to Lathlean (1995) many articles published around the same time indicated that the task of assisting students to learn from coalface clinical situations was more often than not delegated to clinicians (Lathlean, 1995).

Most recently a study by Franklin (2013) that thoroughly examined all models of clinical practice quashed any previous arguments against the early emergence of DEUs. Franklin reviewed the many models of clinical supervision described within the literature and contests the absence of direction as to which clinical supervision model best meets the needs of undergraduate nursing students in the clinical learning environment. Her paper (Franklin, 2013, p. 34) reviews the five clinical supervision models

described by Health Workforce Australia (2011) and establishes that there is strong evidence to ‘support that the facilitator-preceptor and dedicated-education unit models are two models of clinical supervision to best support the clinical learning environment’. In addition, Franklin (2013, p. 39) points out that current literature strongly advocates the position that a DEU ‘supports students in the clinical education environment by fostering critical thinking through reflective practice and the greater opportunity to perform clinical skills and procedures’.

There is no doubt that the current literature supports the notion that a DEU model strongly encourages and fosters a positive clinical education environment. Many authors (for example, Wotton & Gonda, 2004; Ranse & Grealish, 2007; Moscato, Miller, Logsdon, Weinberg & Chorpenning, 2007; Bourgeois, Drayton & Brown, 2011; McKown, McKown & Webb, 2011; Murray, MacIntyre & Teel, 2011; Mullenbach & Burggraf, 2012; Murray & James, 2012) agree DEU’s benefit nursing students, as well as preceptors, facilitators, educational and health faculty staff. There is no doubt that sound relationships are dependant on a partnership between the university and clinical venue that provides an environment for best clinical practice to occur. The next section draws attention to the importance of partnerships in providing undergraduate nursing students with an ideal clinical learning environment.

Strength of partnerships

Over the last decade, the field of research into clinical learning in the workplace and community for nursing undergraduate students has received extensive attention. Several studies have described student perceptions of clinical placement (Dunn & Hansford, 1997; Edwards, Smith, Courtney, Finlayson & Chapman, 2004; Henderson, Heel, Twentyman & Lloyd, 2006). Early work by Dunn & Hansford (1997) surveyed 229 undergraduate nursing students using the Clinical Learning Environment Scale, looking

specifically at 'staff-student relationships, nurse manager commitment, patient relationships, student satisfaction and hierarchy and ritual' (p1300). This was supported by qualitative data obtained from student interviews. It was found that interpersonal relationships between the participants in the clinical learning environment were crucial to the development of a positive learning environment. It was also found that nurse educators, and clinical venues must collaborate in order to create a clinical learning environment that promotes the education of registered nurses capable of providing competent patient care. More recently Twentyman & Lloyd (2006) assessed undergraduate nurses' perceptions of the psychosocial characteristics of clinical learning environments within three different clinical placement models (preceptor, facilitator and clinical unit models). Their study asked 389 nursing students to rate their perceptions of the psycho-social learning environment using a Clinical Learning Environment Inventory (Chan 2003). Their results suggested that clinical education units provided greater psychosocial support for students than traditional models and were more sustainable through their placement of greater numbers of students.

Others have evaluated programs to improve the clinical placement experience (Chan, 2003; McKenna & Wellard, 2004; Lloyd & Bristol, 2006). Chan (2003) surveyed 108 nursing students to assess their perceptions of the clinical learning environment. Chan's study found that students preferred a positive and favourable clinical environment and that clinical placements might be enhanced if there was an attempt to change the actual clinical environment to match that preferred by the students. This was supported by Lloyd and Bristol (2006) who interviewed ten nursing students who participated in a small pilot study where they were matched with mentors in the clinical environment. These students worked in collaborative practice within an interdisciplinary team and evaluated the model as effective and valuable in the development of professional roles.

Emerging research, however, has explored the partnership between faculty and nursing staff on the unit, and how it can provide a synergistic environment to better educate the next generation of nurses.

Niederhauser Macintyre, Garner, Teel & Murray (2010) suggest developing a more structured and cohesive partnership between registered nurses and students. They argue that although the nursing care environment has changed significantly over the past 30 years little has changed in the educational methods used to prepare new nurses. Students are still attending clinical venues in short-block models. This disruptive arrangement can compromise the cohesiveness of the nursing team and limit opportunities for building professional relationships between students, registered nurses and other members of the health care team. Consequently, Niederhauser et al. (2010) claim collaborative partnerships between nursing faculties and health service providers are the cornerstone of successful clinical experience for nursing students – collaborative partnerships, in this sense, have the potential to rejuvenate clinical education in nursing.

Beal (2012) undertook an extensive review of the literature on academic-service partnerships in the profession of nursing, with over 300 articles being accessed. Beal supports the notion that the challenge of providing an optimal learning environment is enormous, given the current environment in health. It has become apparent to many leaders in organisations who attempt to address the clinical learning environment that they must develop partnerships with others in the education-care continuum. Beal (2012) claims that as this realisation comes to consciousness, these leaders are becoming more aware of the need for partnerships as the foundation of a different type of strategic response. In taking early steps towards a partnership, leaders are becoming sensitive to the different demands that a true partnership places on them and their colleagues.

Much work on partnerships has been developed by earlier researchers (Edgecombe et al., 1999; Wotton & Gonda, 2004; Ranse & Grealish, 2007) who suggest that a flexible model of clinical education can provide students

with a positive clinical learning environment that maximises the achievement of student learning outcomes and capitalises on the expertise of both clinicians and faculty. In a more recent study Murray, Crain, Meyer, McDonough & Schweiss (2010) contend academic and health care services can build sustainable models of partnerships that strengthen relationships and increase resources to enhance clinical competencies essential for undergraduate nurses for their entry into practice. The small study by Murray et al. (2010) of 13 students and 16 preceptors collaborated to implement an innovative academic-service partnership model. Prior to the clinical experience students were immersed for two days in a high-fidelity simulation laboratory to prepare for clinical scenarios that could be encountered in the actual clinical environment. A faculty member was appointed as a coach to help guide the preceptor. Student feedback about the experience was positive with students sharing that the partnership model enabled them to better learn prioritisation and delegation. Preceptors agreed that the partnership model made the student more like “part of the team” rather than a “visitor” on the unit (p257).

The partnership established in this study attempts to investigate whether a Flexible Clinical Education Model provides a synergistic environment between clinical industry and academics to best educate the next generation of nurses. Partnerships are supported by the framework created by Wenger (1998); he reviews the role of Communities of practice as an innovative way for educators and practitioners to collaborate, developing and managing new knowledge and emerging practice. Wenger (1998) contends that such communities of practice provide a potentially useful practice-based framework for constructing work-based collaborative learning and promoting engagement with local and professional groups, and communities.

Communities of Practice

Communities of practice are social groups formed to develop specialised knowledge and learning based on practical experiences. Etienne Wenger coined the term ‘communities of practice’ and has defined it as a group of people who share an interest, a set of problems or a passion about a topic and which deepen the knowledge and expertise in the area through a continuous interaction that strengthens their relationships. Communities of practice have since been studied further by Wenger (1998), Wenger, McDermott & Snyder (2002), Garrido (2003) and Saint-Onge & Wallace (2003).

Communities of practice enables knowledge transfer within informal networks and social groups. It offers a formal structure that can acquire more knowledge through shared experiences within the group. This has been acknowledged in other studies (Ranse & Grealish, 2007; Andrew et al., 2008). The group’s identity is reinforced, as learning is a process of sharing, participation and leadership. Informal leadership is essential in organisations and has a role in publicising the group’s work and observing its implementation in practice (Garrido, 2003). Knowledge sharing may be done in person or online; it is always cooperative in a continuous process of establishing strategies for participation, leadership, identity, knowledge capture and use.

Wenger (1998) claims communities of practice enable explicit knowledge transfer within informal networks and social groups. It offers a formal structure that can acquire more knowledge through shared experiences within the group. The group’s identity is reinforced as a process of participation and leadership is shared. Informal leadership is essential in organisations and has a role in publicising a group’s work and observing the implementation of that work in practice. There are many facets to communities of practice; the following section provides the reader with its key elements. This is followed by a discussion on how communities of practice align with education, nursing, ethnography and the Flexible Clinical Education Model.

Communities of practice provide an opportunity to create a learning community around an area of interest or practice in order to share and develop practice and build personal and professional knowledge and expertise. Wenger, et al. (2002, p.4) describe communities of practice as ‘Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in the area by interacting on an ongoing basis’. Wenger et al. (2002) revealed that like-minded people, in areas as diverse as apprenticeships, insurance, oil and engineering companies, formed communities within the workplace; they also observed that wherever these communities occurred they shared three common domains: knowledge, community and practice (Wenger et al., 2002, pp. 4-5).

Knowledge: This is the field of interest shared by the community. It creates a common identity, bringing people together to share their learning. An example of this might be considered as the understanding that Wenger offers regarding knowledge. From this, it can be thought of as the definition of research or study area shared by members of the community (Wenger et al., 2002). Within this study knowledge refers to nursing theory, practice and care.

Communities: Communities of practice refers to community members who are part of the process, step in and share a common interest in the domain of the community. Participants engage in joint activities, in which they share knowledge and support each other. To understand how the community is important, there is a clear illustration of the set of practices that occur within it. Within

this study ‘community’ refers to academics, preceptors and students.

Practice: It is the practice or activity that is shared in common among all the community’s participants. Members share their expertise, and examine theme and develop resources to share. Within this study practice refers to the learning of undergraduate nursing student.

Figure 2.1 outlines the three elements in a community of practice and how they relate to this study.

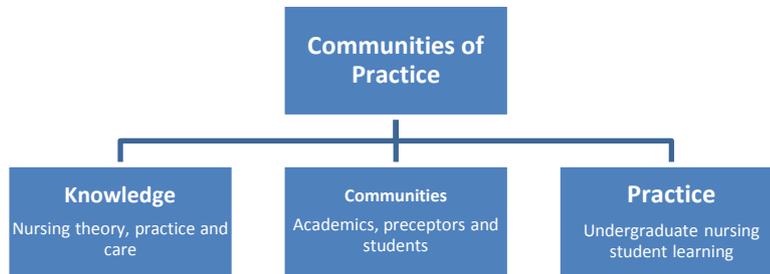


FIGURE 2.1 COMMUNITIES OF PRACTICE AND THE CURRENT STUDY

Among the many challenges of facilitating adult learners is diversity among learners. A study by Papalia (2009) recognises that psychologists have made significant progress in understanding the psychological processes involved in how people vary their approach and preferences to learning styles. In the adult education literature, Leonard (2009) suggests that communities of practice generally belong to the learning theory of ‘constructivism’, where learning occurs in groups and members can learn from and with each other, constructing knowledge in a personal and meaningful way.

Papalia (2009) claims that there are three broad perspectives relating to three theories of learning: behaviourism, cognitive theories and constructivism. Behaviourism focuses only on the objectively observable aspects of learning. Cognitive theories look beyond behaviour, to explain brain-based learning. Constructivism views learning as a process in which the learner actively constructs or builds new ideas or concepts. Hill (2002) elaborates that behaviourism and cognitive theories support the practice of analysing a task and breaking it down into smaller pieces; in contrast, constructivism encourages a more open learning experience, where the

methods and results of learning are not easily measured and may vary from learner to learner (Chowdhury, 2006).

The experiential learning theories of John Dewey (Dewey, 1938) and David Kolb (Kolb, 1999) serve as the foundation for constructivist learning theory. Dewey (1938) understood experience to have a primary role in learning and believed in the relationship between the process of life experience and the process of education. While Kolb (1984) expanded by noting experiential learning "offers the foundation for an approach to education and learning as a lifelong process that is soundly based in the intellectual traditions of social psychology, philosophy, and cognitive psychology" (p. 2).

Social constructivism encourages the learner to become a member of a particular culture or community, and stresses the importance of learners' social interactions with knowledgeable members of the society (Eggen & Kauchak, 2004). Social constructivist theorists view learning as an active process, where learners discover principles, concepts and facts for themselves in a process that encourages critical thinking and reflective practice. Papalia (2009) expands this, asserting that social constructivists use the principles of adult learning, believing that the facilitator and learner are equally involved in learning from each other. Facilitator characteristics encourage students to discover the principles for themselves, and to construct knowledge by working to solve realistic problems. Clarke (2002) contends that human-to-human interaction increases retention of information and skills learned. This supports Lave & Wenger's (1991) communities of practice in which social interaction is not an option that makes learning fun; rather, it is a condition necessary for effective learning.

Constructivists believe learning is an active and social process. It is often referred to as 'social constructivism', and is strongly influenced by Vygotsky (1978), who suggests that knowledge is first constructed in a social context and is then appropriated by individuals. Wilson & Cole (1991) contend social learning approaches, within a communities of practice model, view formation

of community as an essential part of the learning process. Estabrooks, Thompson, Lovely & Hofmeyer (2006) maintain that community formation is essential for both the production and transfer of knowledge. Eggen & Kauchak (2004) conclude that social constructivism influences the learning that occurs with undergraduate nursing students.

Lave and Wenger (1991) recognise that communities of practice are social structures involving relations of power, and acknowledge that the way power is exercised can make legitimate peripheral participation either an empowering or disempowering experience. Furthermore, they acknowledge that newcomers pose a threat to experienced staff thus creating a dynamic tension between continuity of the community and displacement by the young of the old as, 'each threatens the fulfilment of the other's destiny, just as it is essential to it' (p. 116). However, in most if not all of the examples they give, communities are described as rather stable, cohesive and even welcoming entities. Lave and Wenger's (1991) focus on participation in social practice, as a prime determinant of workplace learning, however, further dimensions need to be added to Lave and Wenger's original account. For example, this study showed evidence that experienced nurses are also learning through their engagement with novices (see pg 85), and that part of the process of legitimate peripheral participation for many novices is to help other staff to learn.

Lave and Wenger (1991) are overly dismissive of the role teaching plays in the workplace learning process and of learning in off-the-job settings. Other writers have begun to address this limitation by focusing on workplace pedagogy and the creation of strategies and environments to support it (see for example, Engeström, 2004; Billett, 2002; Fuller, Hodkinson, Hodkinson & Unwin 2006). These authors include approaches which enable employees to participate both on and off the job and in so doing, experience the pedagogic benefits of engaging in communities of practice within and beyond the workplace.

Although Lave and Wenger (1991) acknowledge the significance of learner identity, they never fully develop this idea in relation to particular learners. Where they do address it (see also Wenger, 1998), they focus almost exclusively upon the ways in which belonging to a community of practice helps form a person's identity. But equally important is what the learner brings to that community, from outside. Lave and Wenger acknowledge, but never fully explore, the significance of conflict and unequal power relations as part of their theorising on the internal operation of communities of practice and its relationship with the wider context.

Communities of practice system in nursing is a process of social learning, which emerges when people share a common interest in collaborating with each other. This takes place over a period of time, and is an ideal way to share ideas, find solutions and create new objectives. Barnett et al. (2008) claim the notion of a broader learning community further encourages the move away from the traditional clinical teacher model of education towards one that encourages engagement of a greater number of staff. In nursing, the aim of this collaboration is to provide good patient health care: the community of practice designates the group of people involved in these interactions.

Communities of practice theory, as formalised by Wenger (1998), is part of an epistemological evolution in knowledge management. This theory advocates a social perspective of learning inserted into the collective practices of nursing within communities. This position offers an original reading of the phenomena of collective learning and allows it to be considered from a different point of view. The objective of a learning community in nursing is to increase collective knowledge, through the involvement of each participant in developing individual knowledge. This study closely observes the partnership between clinical industry and universities and examines how a flexible clinical education model

development can create a communities of practice that has student learning as the central focus.

Communitites of Practice in nursing

Lave and Wenger have described the role for learners in communities of practice as 'legitimate peripheral participation' (Lave & Wenger, 1991; Wenger, 1998). Legitimate peripheral participation allows students to enter the world of old timers, to participate in increasingly complex activities, and to develop identities as group members (Lave & Wenger, 1991). According to Lave & Wenger (1991) a community of practice consists of groups of individuals engaged in the same occupation, or in the same career. In nursing, individuals interact on an ongoing basis to control and improve the knowledge and expertise in their field of interest. Thus participation, in which learning about nursing unfolds, remains a driving force in a community of practice, and has a double sense of involvement and commitment. Kimble, Hildreth & Bourdon (2008) argue that mutual engagement, joint enterprise and a shared repertoire are among the important characteristics of communities.

Wenger, McDermot & Snyder (2002) claims a learning community in nursing comprises a group of individuals working together over a defined period to complete a specific nursing task in order to understand a new phenomenon or to complete a collaborative task. At the nurse education level, Wenger et al. (2002) outlines a community as a group of students and at least one educator who, for some time, continue to attain knowledge, skills or attitudes, fuelled by a common vision and will. Attention, dialogue and cooperation are fundamental in this type of community.

The learning community in nursing can also call upon experts for information about particular topics. Laferriere (2005) suggests that teachers and senior nurses are also participants, with the common goal of helping nurses to develop skills essential to the twenty-first century through the empowerment of thought, skills transfer, and complex problem solving and collaboration. Laferriere continues by proposing that internet access can

enable reconciliation and dialogue between people of different geographic locations and cultures, and who have different representations. Indeed, this supports communities as network-related, appropriate to social constructivist theory. Based on this conception, Laferriere (2005) concludes that the learner builds thought individually and collectively by drawing on the cultural artefacts of the immediate community and society in general. Verifying the communities of practice model in nursing is a process of social learning which emerges when people have a central, common interest in collaboration.

This collaboration, which takes place over a period of time, is significant for sharing ideas and finding solutions. Ransie & Grealish (2007) claim communities of practice models promote accountability: students function as part of a team, with responsibilities for client care appropriate to their level of education and experience. Wenger et al. (2002) contends that the objective of a learning community in nursing is to increase collective knowledge through the involvement of each participant and to develop individual knowledge. Berry (2011, p. 1) combines these elements of educational theory and practice to create a set of capacity-building relationships, thus:

Re-envisioning the relationship between education and practice using Wenger's communities of practice model promotes the development of mutually beneficial, capacity-building relationships where learning and growth are goals for students and staff alike.

Ultimately, the aim of developing collaboration with communities of practice is to provide quality health care to patients.

Communitites of Practice in education

Communities of practice in education refers to social group formation to develop an educational environment within a community. Learning as social participation is a primary focus of Wenger's more recent work (Wenger, et al. 2002). Secondary schools and higher education sectors have enthusiastically taken up communities of practice (Brown & Campione, 1995; Laferriere, 2005; Hildreth & Kimble, 2006; Kimble et al., 2008;). Communities of

practice were first used in teacher training in providing isolated administrators access to colleagues. It was followed by a wave of interest in peer-to-peer professional development activities (Wenger, 2010). Communities of practice perspective in tertiary schools has impacted greatly on changing traditional boundaries that are often associated with learning theory. What has evolved through the inclusion of communities of practice in the tertiary education context are profound transformations for both staff and students. Wenger (2010) suggests how communities of practice impact on educational practices through an analysis of the internal and external spaces that students occupy and how these spaces are lived out across their lifespan.

Internally: This refers to organising educational experiences that ground learning in practice, through community participation in subject matter. This is achieved by collaborating with industry and academics to ensure theoretical learning is aligned closely with industry requirements for each clinical placement.

Externally: This involves connecting the experience of students to practice through peripheral forms of participation in broader communities beyond the walls of a tertiary environment; the clinical learning environment provides nursing students with opportunities to place theoretical knowledge into practice by consolidating through doing.

Over the lifetime of students: Serving the lifelong learning needs of students by organising communities of practice focuses topics of continuing interest to students beyond the initial learning period. Establishment of communities of practice through the Flexible Clinical Education Model is expected to enable students to accomplish techniques for procedures they will continue to perform throughout their career. This will also include non-nursing procedures, such as mannerisms.

From this perspective, the education provider is not the central focus of learning, but rather students gain knowledge as part of a wider learning system. Wenger's communities of practice applies the notion that the community is an appropriate domain for professional learning and signifies

the importance of quality interactions between students, teachers and pre-service teachers in education. Effective partnerships have a focus on learning for all stakeholders, with student learning as the principal focus, enabling connections to be made between the contributions from each partner (Kruger et al., 2009).

Communitites of Practice and the Flexible Clinical Education Model

The Flexible Clinical Education Model is informed by Wenger's (1998) social theory of learning communities of practice . Engagement and participation in the clinical workplace are essential for nursing students. The communities of practice theory provides a framework to understand the ways that students learn and identify as nurses in clinical placements. Strategies to support learning in the workplace can be shared between students and clinicians as nursing students engage in the workplace through practices of participation and non-participation. The Flexible Clinical Education Model enables nursing students to have extended exposure to learning in the clinical environment.

The Flexible Clinical Education Model requires formal partnerships and commitment between education and practice. Each ward is used by only one school of nursing and has an assigned clinical facilitator. Murray et al. (2010) assert the clinical facilitator supports the questioning of practice and works with both students and academic staff. Theoretically, using the premise of social learning, students in the Flexible Clinical Education Model are exposed to a culture of learning by observing and working under the guidance of experienced nurses. Preceptors have a continuing relationship within the Flexible Clinical Education Model and participate in the ongoing learning activities on the ward. Berry (2011) claims preceptors play an important role in educating other clinical staff about how to teach and support students. In the Flexible Clinical Education Model, students attend the same ward for a minimum two days a week for the entire semester and

are encouraged to take an active role on the ward in ongoing interaction with staff from many disciplines.

Several studies have acknowledged the value of nursing students being accepted and incorporated into the ward environment (Dunn & Hansford, 1997; Nolan, 1998; Jackson & Mannix, 2001). Nolan (1998) reports that nursing students believe that their learning was superficial if they were not accepted as part of the clinical team. This has been supported in other studies (Ranse & Grealish, 2007; Andrew, Tolson & Ferguson, 2008), where the group's identity is reinforced when learning is viewed as a process of sharing, participation and leadership. Berry (2011) continues by asserting the sharing of knowledge is always cooperative in a continuous process of establishing strategies for participation, leadership, identity, knowledge capture and use. Garrido (2003) concludes informal leadership is essential in organisations and has a role in publicising the work of the group and observing the implementation of their work in practice.

The current research and conversations suggest that the traditional model of clinical education is not providing undergraduate nursing students with opportunities to make use of their knowledge and skills; nor does it develop the attributes that enable them to succeed in the field. It has become clear that a collaborative model of professional practice is needed to reinvigorate practice both in the field and in academic teaching. Using communities of practice to build strong partnerships will enrich student learning and facilitated links between theory and practice and contributed to the development of professional networks. This may ultimately lead to providing best practice in the clinical environment.

Best practice clinical learning environment

In May 2008, the Victorian Department of Human Services (now the Department of Health) commissioned the *Best Practice Clinical Learning Environments* (BPCLE) project, to examine the nature of successful clinical

placements and develop a model of best practice. The project was part of a comprehensive strategy developed by the department, aimed at enhancing the capacity and quality of clinical placements in medicine, nursing and allied health in Victoria (Darcy Associates, 2012).

The Best Practice Clinical Learning Environments BPCLE framework provides a guide for health services and training providers to coordinate and deliver high-quality clinical placements for health students. From the report, Darcy Associates (2009, pp. 75-78) identifies six key characteristics of high-performing clinical learning environments identified in the Best Practice Clinical Learning Environments framework: an organisational culture that values learning; best practice clinical practice; a positive learning environment; an effective health service-training provider relationship; effective communication processes and appropriate resources and facilities.

Traditional education has been studied over time for the purpose of documenting what constitutes best practice in clinical learning. Incorporating the six key elements in a clinical education model is a move towards a situation in which student learning is central and valued, and which leads to the establishment of communities of practice. In chapter 5, these six elements are used to understand and explain the experiences reported in this research.

Summary

This chapter has presented a comprehensive understanding of how the Flexible Clinical Education Model can best provide the learner with opportunities to maximise learning within a social constructivism theory. Social constructivism complement the principles of communities of practice, on which the Flexible Clinical Education Model was designed. Communities of practice have been considered and a discussion on how they enable transfer of knowledge within informal networks and social groups has been presented. It has been explained that communities of practice can be used in education and nursing by offering a formal structure that assists undergraduate nursing students to acquire

knowledge through shared experiences within the group. Chapter 2 has provided a detailed review of the current literature which introduces models of clinical practice, and which discusses how partnerships and communities of practice support theories of social constructivism that underpin the Flexible Clinical Education Model. This chapter also introduces the Best Practice Clinical Learning Environments project.

CHAPTER 3

Methodology and Research Design

Introduction

This chapter presents the philosophical stance of the study, commencing with ethnography as its research design. This is followed by a discussion on how ethnography supports communities of practice in nursing, education and the Flexible Clinical Education Model. The final section of this chapter presents a detailed discussion on the study design, including ethical considerations, limitations of this study, methods of data collection and data analysis.

Ethnography is a qualitative research method that involves observing the practices of human groups, and enables the researcher to participate as a group member (Brewer 2000). Ethnography is an appropriate methodology because the theory of learning informing the Flexible Clinical Education Model is a social learning theory. According to sociologists Giddens & Griffiths (2000), ethnography is the direct study of individuals or groups for a certain period using participant observation or interviews to learn social behaviour that reveals a realistic and faithful image of the group studied. Moreover, it applies to the study of communities and any group that a person wants to know better and understand.

Wenger (1998), defines learning as active social participation in the practices of a community (Lave & Wenger 1991, Wenger 1998), and emphasise the dynamic interaction between people and the environment in the construction of meaning and identity. Brewer (2000) elaborates that ethnographic fieldwork is especially well suited to studying interactions

among members of a defined community, such as the relations between clinicians and students in a ward environment.

Communities of practice and ethnography combine to develop knowledge about nursing or educational practices. Scardamalia (2000) maintains that communities of practice in nursing and in education include individuals who engage in the production, the proposal and the sharing of ideas and knowledge to advance their community. An ethnographic approach was used in this research as it required the researcher to be immersed in a group for an extended period of time observing behaviour, listening to what was said in conversations, and asking questions (O'Reilly, 2008). Observation and field notes were taken during the study and the ethnography was validated by a series of interviews at the conclusion of the study.

Creswell (2007) suggests that, as other methodological decisions flow on from and inform the design, the claims underpinning a philosophical approach must be made explicit early in the research process. Stating a claim means that researchers begin a project with certain assumptions about how and what they will learn during their inquiry. Creswell (2007, p. 25) asserts that philosophically, researchers make claims about the nature of reality (ontology), what constitutes knowledge (epistemology), what values underpin the study (axiology), the language of the study (rhetoric) and the research process (methodology).

Thus, a qualitative research methodology has been used to provide a pathway for drawing out the real life experiences of participants as it is a form of social inquiry that focuses on the way participants interpret and make sense of their experiences.

Research Aims

This study aims to explore how a partnership between university faculty and clinical nursing staff could provide a community of practice environment to best educate the next generation of nurses. It also aims to explore how the

Flexible Clinical Education Model may enable students to develop a sense of satisfaction with their clinical learning experience. The Flexible Clinical Education Model aims to provide students with a positive clinical learning environment that maximises the achievement of learning outcomes and capitalises on the expertise of both clinicians and faculty.

Research questions

The purpose of this study was to look at a model of clinical learning that provided the best possible education for current and future nurses. The study also aimed to examine how the Flexible Clinical Education Model enabled students to develop a sense of satisfaction with their clinical learning experience. As introduced in Chapter 1, the overarching research question for this study is as follows:

How can a Flexible Clinical Education Model enable nursing student learning to be central and valued?’

There were four contributing research questions:

1. How can the Flexible Clinical Education Model provide academics and clinicians the preparedness to meet the objectives of student placements?
2. How can the Flexible Clinical Education Model practice a genuine partnership between academics and clinical agencies?
3. How can the Flexible Clinical Education Model provide nursing students with satisfaction of their clinical experience?
4. How can the Flexible Clinical Education Model be sustainable within the Bachelor of Nursing?

The following is a discussion on ethnography, communities of practice and how they inform the study design about the Flexible Clinical Education Model.

Ethnography

An ethnographic approach was used for this research, as this method requires the researcher to be immersed in a group for an extended period, observing behaviour, listening to what is said in conversations, and asking questions

(O'Reilly, 2008).

Ethnography is an appropriate approach because the learning theory informing the Flexible Clinical Education Model is a social learning theory. Ethnographic fieldwork is especially well-suited to study interactions among members of a defined community, such as the relations between preceptor and student in a ward environment.

In this study the need to look at student learning and practices necessitated the use of ethnographic methods; fieldwork and in-depth interviewing, supplemented with focus group interviews, facilitated the discovery of patterns and themes that emerged from the data. Observations and field notes were made during the research phase, and data were validated within the focus groups and individual interviews at the study's conclusion. Ethnography was chosen as an appropriate approach for inquiry into the unexplored human and social phenomenon of nursing practice in a clinical ward environment (Hammersley & Atkinson, 1995; Spradley, 1980). At an exploratory level of naturalistic inquiry, ethnography provided flexibility to explore and describe the culture of nursing practice within the social context of nurses' daily life (Streubert & Carpenter, 1995).

Ethnography is an appropriate approach because it supports the theory of learning informing the Flexible Clinical Education Model: it is a social learning theory. Ethnography provides a useful methodology that facilitates mutual dialogue among participants, and Manias & Street (2008) claim it is becoming widely accepted in nursing. An ethnographic approach was used for this research, as this method required the researcher to be immersed in a group for an extended period of time, observing behaviour, listening to conversations and asking questions (O'Reilly, 2008).

Ethnography is essentially the study of a particular group or community – in this case, undergraduate nursing students and nursing staff in a clinical environment. The field is an important branch of scholarly study. Ethnographic research aims to reveal the meanings that underlie actions and interactions constituting the social reality of the studied group. O'Reilly

(2008) advise this is achieved through the direct involvement of the researcher. Often, the researcher takes an active role in daily activities, observing what is happening and asking for explanations and interpretations of the observed decisions, actions and behaviours. For these reasons, ethnography was ideally suited to this study.

According to Giddens & Griffiths (2000), ethnography provides information on social life far better than most other qualitative research approach. Once it is known how situations look from within a particular group, ethnography can provide a deeper understanding of why certain people act in a given way. From this, the researcher is able learn more about the social processes that overlap the situation being studied. In this study, ethnography also gave the researcher greater flexibility, allowing the researcher to adapt to new and unexpected opportunities that arose during the study.

Ethnography and nursing

In nursing, ethnography involves the social processes and cultural representations of health, the diseases encountered, and the practices of care and assistance related to it. Early studies by Good (1994), Nichter (1993) & Rapport & Maggs (1997) advocate ethnography in nursing to look for ways to meet the humanitarian and scientific demands of health care and has been used in a number of early nursing studies relating to illness. More recently, it has proven a popular methodology for investigating the practice of nursing (De Silva, 2009; Rankin & Campbell, 2009; Chuo, Magarey & Weichula, 2012).

Ethnographic studies consist mostly of observations, interviews and discussions to ascertain how people perceive health and illness, and how society, culture, politics and environment positively or negatively affect health. Catherine Pope in her QUEST discussion seminar (2013) describes ethnography as ‘telling stories’ and how it uses the researcher as the research instrument. Such research is done to examine the obstacles faced by people seeking medical help and health care. This knowledge helps nurses provide

improved health care through better and culturally sensitive communication. Using ethnography for the current study enabled the researcher to observe closely the interactions between clinical preceptor staff and nursing students, and to examine intricate details as learning occurred. With the close involvement required for ethnography the researcher was able to observe, document, analyse and understand more completely what had enhanced student learning.

Ethnography and education

Cultural relativism is an important aspect of ethnography in education. This involves the recognition of independence and the usefulness of each culture, along with every nation's cultural focus (Hopson & Dixson, 2011). Hammersley & Atkinson (1994) propose this plays an important role in education. Ethnographic research in nurse education is becoming increasingly popular, with many studies using this research method. For example, Hunter, Spence, McKenna & Ledema (2008), Timmins (2012), Williamson, Twelvetree, Thompson and Beaver (2012) have all conducted ethnographic studies in nursing. The current study used an ethnographic approach to gain an understanding regarding factors that enhanced student learning in a clinical education environment. Being immersed in this study enabled the researcher to understand what students and staff believed had a positive or negative effect on students' learning.

Ethnography and the Flexible Clinical Education Model

Ethnography opens the way to achieve a better understanding of how the Flexible Clinical Education Model enables students to develop a sense of satisfaction with their clinical learning experience. It also allows a close investigation of the impact on students of experiencing an extended period in a clinical environment. Using the premise of social learning, students in this study were exposed to a culture of learning in which they observed

experienced nurses using a combination of different approaches as part of their professional practice; at the same time, the Flexible Clinical Education Model allowed the nursing students to be active constructors of their own learning, when they are accepted and incorporated into the ward environment. It was expected that the process of students working closely with hospital educators and nursing unit managers might strengthen the professional partnership between academics and clinicians.

Limitations of ethnography

Ethnographic fieldwork has limitations: only relatively small groups or communities can be studied, and the research's trustworthiness depends on the researcher's ability to gain participants' trust and earn the confidence of individuals within the study. Without this ability, it is unlikely that research will move forward. Once the necessary confidence is won, it is also possible that the researcher might be identified as a group member, thus resulting in the researcher losing the perspective of an outside observer (Harris, 2006).

By now the reader will have a clear understanding of why this study used ethnography to show how the Flexible Clinical Education Model was designed to achieve a community of practice. Figure 3.1 demonstrates the three elements; ethnography, communities of practice and a Flexible Clinical Education Model presenting an interlinking of commonalities (e.g., a theory of social learning) with student learning as the central component.

The Flexible Clinical Education Model is informed by Lave and Wenger's social theory of learning. The current study follows the principles of an ethnographic research design that provides a framework for understanding how students identify as nurses during clinical placements. Communities of practice supports workplace learning that can be shared with students and clinicians, as nursing students engage in the work place.

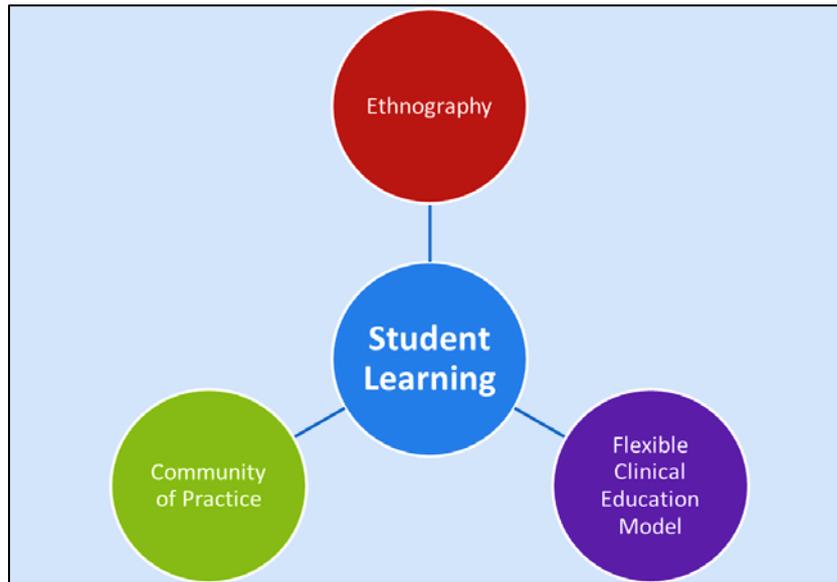


FIGURE 3.1 FLEXIBLE CLINICAL EDUCATION MODEL

Research Design

This section describes the research design and methods used to answer the research questions for the current study. It begins with a discussion focusing on the research design, study participants, data collection methods, data analysis procedures and ethical considerations associated with the study. The chapter concludes with a brief summary of key themes discussed within the methodological framework.

As mentioned in the introduction to this chapter, this research used an ethnographic approach within a qualitative methodology; O'Reilly (2008) claims the researcher needs to be immersed in a group for an extended time. In the current study, the need to look at student learning and practices *in situ* supported the use of ethnographic methods. Fieldwork was supplemented by the use of in-depth individual and focus group interviews. These interviews ensured that participant perspectives were included in the study; these facilitated the discovery of patterns and themes emerging from the data and

enabled confirmation of findings across different stakeholders. This strategy gave the researcher crucial clues into how a partnership between faculty and nursing staff could provide a synergistic environment to better educate the next generation of nurses.

Setting and Participants

This study's focus was on the clinical experience of undergraduate nursing students in a medical and surgical environment. The study was conducted in four wards at Hospital X in Victoria, Australia. Two were surgical wards and two were medical wards. The focus groups were conducted in a classroom booked in the education department of Hospital X. Academic staff were interviewed at Victoria University, St Albans campus and preceptors were interviewed at Hospital X.

Three types of participants were recruited for this study: undergraduate nursing students, clinical ward staff (preceptors) and academic staff. Undergraduate nursing students were participating in the Flexible Clinical Education Model at Hospital X, completing their final semester of the Bachelor of Nursing at Victoria University. Clinical ward staff comprised registered nurses (RN), enrolled nurses (EN), clinical facilitators (CF) and the Nurse Unit Manager (NUM) across the four wards designated as the Flexible Clinical Education Model workplace. Academic staff came from the School of Nursing and Midwifery (SNM) at Victoria University. A summary of participants is contained in Table 3.1.

	Ward A	Ward B	Ward C	Ward D
clinical facilitator x 2 Individual interview and observation	CF1	CF1	CF2	CF2
Nursing unit manager x 2 Individual Interview	NUM1		NUM2	
Clinical ward staff x 3 Observation	P1, P2	P3		
Undergraduate nursing student x 15 Focus Group Interview	S1, S2, S4, S5, S9,	S6, S8, S15	S3, S11, S12, S13, S14	S7, S10,
	Academics not assigned to wards			
Academic x 4 Individual Interview	A1, A2, A3, A4			

TABLE 3.1 PARTICIPANT SUMMARY

Students (15 in total)

This group of participants consisted of undergraduate nursing students in the final semester of the Bachelor of Nursing. Students were enrolled into the semester two unit of study HNB3250: Clinical Practicum 9 Consolidation; they were aged 18 years and over.

These students were specifically invited to participate as the researcher was not involved in any assessment or grading of this group. The researcher sought permission from the unit coordinator to attend a lecture on Monday 6 September 2010, for the unit HNB3250 and distributed Information to Participant forms (2), explained the study and answered questions. The researcher informed students that their participation or non-participation would have no effect on their results. The researcher provided students with her student email address and office phone number, so that potential participants could ask further questions and seek clarification about the study or return signed consent forms. The researcher also informed students that she would be attending an orientation to again present her study and invited students to participate. The lecturer of this unit was not present when the

study was being discussed. No student queries were forthcoming from this session.

The researcher sent an email (2) to the Clinical Facilitator, requesting permission to attend the Hospital X orientation, and was granted permission to attend on Monday 13 September 2010. The researcher provided students with Information to Participants forms (Appendix 1) and again outlined the study's purpose and the students' anticipated involvement. Students were provided with an opportunity to ask questions and seek clarification.

Clinical ward staff (7 in total)

These participants were all employed by Hospital X as registered nurses, either Division 1 or Division 2, and were aged 21 years and over.

For the Flexible Clinical Education Model, there were two designated clinical facilitators (CF1 & CF2): one for the medical wards and one for the surgical wards. The clinical facilitators provided the link between the researcher and the clinical ward staff. Prior to the commencement of the participant observation phase, the researcher was introduced to each nursing unit manager by CF1. At the start of each participant observation session, the researcher announced her presence on the ward to the nursing unit manager and sought the undergraduate nursing student to gain permission and consent to observe them in action. Permission and consent was sought from the preceptor (or 'buddy' in cases where a student was not working with CF1 or CF2).

Academic staff (4 in total)

These academic staff were employed by Victoria University as nursing and midwifery academics level B, and were aged 18 years and older.

The Flexible Clinical Education Model was first introduced to the School of Nursing and Midwifery at Victoria University during January 2008 and December 2009, and was mainly managed by the researcher in her previous role as Academic Advisor Clinical Learning. From January 2010, the

Flexible Clinical Education Model was incorporated into the Bachelor of Nursing as a model of clinical delivery and management was undertaken by the relevant clinical unit coordinator. At the time of interviews only a small number of staff had been a clinical unit coordinator; all were contacted via the researcher's student email address inviting them to participate in this study. All accepted, with one withdrawing from the study after the interview phase. No data from that interview was used in this thesis.

Data collection

The current study employed an ethnographic approach utilising various data collection methods: participant observation; field notes; journal entries; focus groups; academic interviews; preceptor interviews. Observation and field notes were taken during the participation phase and were followed by focus groups with students, and individual interviews with clinical ward staff and academic staff.

Participant observation

Participant observation was accomplished through both observation and participation, in varying degrees, in the students' daily activities in the clinical environment. Borbasi, Jackson & Langford (2008) suggest the researcher become engaged in this data collection method, developing an understanding of the observed participant's experience. They suggest that the practice of participant observation often leads to informal, conversational interviews; the data from these interviews may become field notes or may consist of separate interview transcripts.

The participant observation (PO) phase commenced on Wednesday 27 October 2010. The researcher arrived at 12 noon, as proposed. On arrival at Hospital X, the researcher met with a designated clinical facilitator

Date	Ward A	Ward B	Ward C	Ward D	Summary of activities
PO 1 27/10/10	S1 & P1				Percutaneous endoscopic gastrostomy (PEG) feed and intravenous antibiotics
PO 2 27/10/10	S2 & P2				Transfer to X ray and patient handover
PO 3 03/11/10			S3 & CF1		Medication administration
PO 4 03/11/10			S3 & CF1		Vital signs and care of indwelling catheter
PO 5 03/11/10	S4 & CF1				Glasgow Coma Scale observations
PO 6 03/11/10	S5 & CF1				Developing plan of care
PO 7 10/11/10		S6 & P3			Patient education on managing PEG tube
PO 8 10/11/10		S6 & P3			Transfer from chair to bed
PO 9 10/11/10				S7 & CF2	Care of indwelling catheter

TABLE 3.2 SUMMARY OF PARTICIPANT OBSERVATION

(CF1) and gained permission to observe her in action. Signed consent was sought and gained from each student and preceptor, as per Victoria University HREC approval, and verbal permission was sought and gained from each patient when required. Table 3.2 shows a summary of all the participant observation sessions, outlining the dates, and wards where the observations occurred. Included in this table are staff, students and a summary of the activity observed

Field notes

During each session, the researcher took field notes using an observation template (Appendix 3). While in the ward settings, the researcher made careful notes about what was observed, recording all activities and observations as field notes in a predetermined template. Field notes were immediately captured in writing, recording the researcher's observations, conversations, and

interactions at the field site. On completion of each observation session, a detailed verbal account was digitally recorded and later transcribed verbatim (Appendix 4, excerpt of a transcribed field note).

Researcher's field notes are recognised as a construction of that field experience (Morgan, Krueger, King & Scannell, 1998). Informal conversations and interactions with students and ward staff were also important components of this method, and were recorded in the field notes in as much detail as possible. In summary following the completion of each participant observation session, the researcher used the information from the field notes to verbalise and digitally record a more detailed description of the event. These recordings were then transcribed verbatim and followed the same coding and analyses process of the interviews.

Field notes are a traditional system of ethnographic data recording and are a form of observation. Depending on the ethnographer's commitment and time, the data may be more or less descriptive although the intention is to capture the processes and contexts in full, Spradley (1980) claims what is actually recorded is what is relevant to investigation of the problem, or at least the anticipation of what the researchers have done. In fact, Pallaruelo (2000) suggests the purpose is to first identify and develop what is observed for inclusion in appropriate categories. Field notes are a central activity in the investigation. The researcher has to confirm the aims and priorities, and the costs and benefits that will produce the required strategies, several times throughout the investigation.

Journal entries

Reflective journals are an effective part of data gathering. Currently in nursing, it is very common to have students write in reflective journals as they put their learning into practice (Rolfe, Freshwater & Jasper, 2002; Redmond, 2004). Especially useful are journal entries kept while implementing new ideas, or changing particular behaviours. When starting small and gradually implementing new approaches Auerbach (1990, p. 239) points out: 'it may be

helpful to keep a journal in which you record issues as they come up, write observations, and evaluate new things you try'. At Victoria University, undergraduate nursing students are required to keep a reflective journal for each clinical placement. It was planned these would be collected after all assessments had been completed. These data were to provide information about students' perspective of the learning experience, and hence enable participant observations to be validated.

It became apparent that the documented curriculum requirements were not being adhered to and students were not submitting reflective journals as expected. This placed the researcher in an ambiguous position of acting in a dual role as researcher and Associate Head of School. . This realisation required further investigation in her capacity as Associate Head within the School of Nursing and Midwifery. However, it was deemed inappropriate to expect these students to submit a journal for this particular unit of study just to enhance the researcher's findings therefore, student reflective journals were not collected.

Focus group interviews

In addition to participant observation, focus group interviews were conducted with the students. A total of three focus groups were conducted and a summary can be seen in Table 3.3. A focus group interview is a structured group process used to obtain detailed information about a particular topic. It was particularly useful for exploring attitudes and feelings and to draw out precise issues that may be unknown to the researcher (Morgan et al., 1998). The focus group interviews were used to triangulate findings based on information gained through the participant observations. Open-ended questions were used to explore students' perceptions of their learning.

See Appendix 5 Interview questions for student focus groups.

Focus Group	Date	Attendance
1	Wednesday 17 November 2010	9 students
2	Wednesday 24 November 2010	8 students
3	Wednesday 1 December 2010	11 students

TABLE 3.3 FOCUS GROUP INTERVIEW DATES

Focus group interviews were strategically booked on Wednesday's between 2:00 PM and 3:00 PM. Wednesday was chosen as a consistent day for the researcher to attend Hospital X. This ensured that the Nurse Unit Manager, clinical facilitators, preceptors and students were aware of the researcher's presence. The focus groups were timed to enable students from both shifts to attend; this was the time period when wards had double staff, due to an overlap between morning and afternoon shifts.

Individual interviews

Individual interviews were very useful for gathering in-depth, detailed information. Data collection was based on seeing the world from the participant's viewpoint, and information obtained from the interviews was vital because results and conclusions were based on the data (Schneider, Whitehead & Elliot, 2007). For this reason, individual, in-depth qualitative interviews were also conducted with clinicians from Hospital X and academics from the School of Nursing and Midwifery. According to Webb (2003), when reporting qualitative research it is essential, initially, to collect data using open-ended questions these should then be followed by more probing questions. For example, academic interviews commenced with an open ended questions such as, 'Can you tell me what information you are provided with when preparing for a clinical unit of study?' This was pursued with more specific questions such as, 'Can you tell me more about that?' in an attempt to more fully examine the person's feelings and thoughts, uncovering their values and perceptions on coordinating a clinical unit of study. The interviews obtained

were personally transcribed by the researcher to relive the interviews and develop a feeling for the meanings expressed by the participants (Polit & Beck, 2004).

Academic interviews

Academics who agreed to be interviewed were offered a choice of where they were interviewed. All but one academic was interviewed in the researcher's office at Victoria University, St Albans campus. The other academic was provided with a phone interview, as the researcher was not on campus the day most suitable for the first academic. All interviews lasted between 30 and 45 minutes and followed the same format, using questions designed around the research questions (Appendix 6, Interview questions for academics).

Clinical Ward Staff interviews

From the seven clinical wards staff, two were observed during participant observation sessions and five were interviewed. All interviews occurred at Hospital X. Two interviews were held in the privacy of the clinical ward staff's own office; three were conducted in a pre-booked classroom in the education department, Hospital X. All interviews lasted between 25 and 40 minutes and followed the same format using questions designed around the research questions (Appendix 7, Interview questions for preceptors). All interviews were transcribed verbatim by the researcher.

Ethical considerations

Ethical clearance to undertake this project was obtained from Victoria University Human Research Ethics Committee, and Hospital X Human Research Ethics Committee.

Potential risks

Management of the potential risks was identified and each of these potential risks is addressed below.

Participant rights

Participants were fully informed about the purpose of the study and the way in which information was to be used. They were advised that: (i) participation is voluntary; and (ii) they could choose not to answer any question that might cause discomfort. Participants were advised to offer only that information with which they were comfortable to share with others; they were advised not to answer questions which were uncomfortable for them. All data were de-identified after collection and were analysed without acknowledging the individual.

The researcher did not coerce participants to take part or remain in the study. Participants were advised they were free to withdraw from the research at any time; one participant exercised this right.

Role of researcher and relationship to students

The researcher is currently employed with Victoria University as Associate Head, School of Nursing and Midwifery (SNM). The researcher specifically nominated this cohort of students as she was not involved in teaching or assessing any third-year nursing students during Semester 2, 2010. This cohort of students finished their studies with the SNM at the completion of 2010. Nursing students were fully informed about the purpose and aims of every aspect of the research.

Role of researcher and relationship to clinical ward staff and academic participants

In the researcher's previous role as academic advisor: clinical learning, she was invited to attend numerous staff development meetings, ward staff

meetings, unit manager meetings and student orientation sessions. During this time, the researcher developed and maintained a strong professional relationship with staff involved with the Flexible Clinical Education Model, including the executive Director of Nursing for Hospital X.

The researcher took measures to be as unobtrusive as possible in the clinical environment. The researcher was an additional person in the ward; she did not participate in direct patient care; nor did she make any contribution to, or verbal comment about, the nursing team dynamics. The researcher maintained a professional relationship with clinical staff and provided reassurance of confidentiality and anonymity.

The researcher was only interested in recording the actions of the undergraduate nurse and the preceptor, and maintained professional boundaries; she exercised sensitivity when performing individual interviews with academics and preceptors.

Researcher's qualifications, knowledge and experience and ethical behaviour

The researcher, as a result of past training and experience as a registered nurse, was sensitive to the emotional responses and needs of participants during the interviews. The researcher debriefed participants during and at the end of the interview as deemed appropriate. The researcher understands nursing practice and was able to recognise situations when she needed to remove herself.

Ethical behaviour during participant observation

The researcher was prepared to leave the ward if requested by the ward staff or their supervisor. At no time during the observations was the researcher asked to leave; however, on one occasion the researcher removed herself from the room during a procedure to respect the patient's dignity and privacy. This situation occurred during PO 8, when the researcher thought she would be observing a student transfer a bilateral amputee from chair to bed. Once it became apparent that the student was required to assist this patient with a bedpan, the researcher removed herself from the area and no data were used

from that observation.

Ethical behaviour during focus group and individual interviews

The researcher conducted herself with professionalism and integrity and was aware of possible conflicts of interest, in particular with her role as Associate Head of School. The researcher was aware of obligations to maintain confidentiality of information and ensured data were properly protected during the course of study. The researcher respected the dignity, diversity and rights of individuals and groups of people and exercised due skill, care and diligence when performing individual and focus group interviews.

Confidentiality

Participant confidentiality was protected in this study through coding. Each participant was given a code and referred to by that name in the transcripts and in any publications or reports arising from the study. For example, two designated CFs have been identified only as CF1 and CF2. Originally, it was anticipated that pseudonyms would be used and wherever a pseudonym is used through out this thesis a * follows the name to denote a pseudonym has been used. However, when writing Chapter 4, there was no clear way of identifying which quotes came from academics, preceptors or students, other than to write the pseudonym followed by the designation, for example Mary* (academic). It was at this point that the researcher decided to also identify each cohort by the designation and the order in which they were interviewed, for example Academic 1, Preceptor 1 and Focus group 1. Only the researcher has access to the names and details of participants and the order in which they were interviewed. The digital recordings and the transcribed notes are stored in a locked filing cabinet in the School of Nursing and Midwifery. The consent forms are stored in a separate locked filing cabinet, as per Human Research Ethics Committee approval.

Data analysis

Once data has been analysed it must be presented, according to Huberman & Miles (2002) in an easily accessible format. This presentation might be a transcript from an interview or focus group, a series of written answers on an open-ended questionnaire, or field notes or memos written by the researcher. It is useful to write memos and notes as soon as data collection commences, as they assist with focusing on significant points emerging from the data. Huberman & Miles (2002) go on to suggest that these memos and notes should be coded and analysed along with the transcripts. A detailed discussion on how the data for this study were analysed is presented below, commencing with triangulation.

Triangulation

Data from this study were collected using four collection methods: individual interviews, focus group interviews, and participant observation and field notes. According to O'Donoghue & Punch (2003), data triangulation occurs when a piece of data, a finding, or a generalisation is able to be verified using several different research methods. In this research, data from each collection method were analysed individually, then compared against each other for similarities. This added to the credibility of the research, ensuring reliability in the findings.

The field notes, focus group and individual interview transcripts were examined closely. Information and responses were coded and categorised into themes. The themes were then compared to the literature and the differences, relationships and similarities were determined. Experts (Holloway & Wheeler, 1996; Polit & Beck, 2004) recommend that researchers transcribe interview data themselves, because it is an effective way to become immersed in the data. This method provides more time to listen, analyse and note details about issues such as voice tone. All interviews were transcribed verbatim and read a number of times, allowing the researcher to become familiar with the content.

Focus groups and individual interviews

The researcher transcribed all focus group and field notes, ensuring a rich understanding of the data. Focus group data analysis commenced with the digital recording being transcribed verbatim with detailed notes taken to assist in identifying for emerging themes. Data were analysed thematically.

Thematic analysis

During data analysis and interpretation, transcripts from interviews, focus groups and field notes were studied intensively and the main issues articulated by the participants were highlighted and coded using themes and meaning units. This resulted in the cluster of four broad categories: communication, reflective practice, balance and commitment. Thematic analysis is a general method for qualitative analysis of transcripts or other similar text data sources. It is applicable to ethnography methodology and is commonly used in nursing research (Clancy, 2011; Fry, 2001; Ryan, Goldberg & Evans, 2009).

Data were thematically analysed using a six step-by-step approach to thematic analysis (Kostere & Percy, 2006). This method of analysis was chosen as it clearly and simply identified a process that was coherent and logical to the researcher. All data were transcribed verbatim and coded following the framework designed by Kostere & Percy (2006) and can be viewed in Table 3.4.

Step	Process
1	Prepare data and transcript
2	Identify meaning units
3	Group patterned meaning units
4	Generate theme statements
5	Tables or matrices of themes and meaning units (instances of themes)
6	Summary of the themes

TABLE 3.4 THEMATIC ANALYSIS PROCESS

Meaning unit	Participants response	Emerging theme
	And that leads onto the next question which is, "Do you think that the flexible model um, helps build a professional relationship between the university and the facility?"	
	Yeah. Um, but certainly much more partnership orientated because, like I said it was still a little bit of an experiment. Um, certainly at Hospital X. Um, on such a big scale, you know like um, I don't know what your experiences were when you were looking after flexible learning model, but because it was my first time with ah, 'cause, and I didn't feel like I was prepared because it didn't occur to me until the semester had started. Oh my God, it's the flexible model in here, what's all this about?	

TABLE 3.5 EXAMPLE OF TRANSCRIPT PREPARATION

Step 1: Prepare data and transcript

The data was transcribed accurately and a master copy was preserved separately so that it was not worked on or altered from the original recording, margins or format. A working copy was prepared with two wide margins and the participant's response was double spaced. Table 3.5 provides an excerpt of how the data were transcribed and structured in preparation for analysis to commence. The entire master transcript was read for meaning and sense before any comments were made.

Step 2: Identify meaning units

Participants responses were read closely and common words or phrases were noted using a **yellow highlighter**. The meaning of these words or phrases was then summarised into a smaller meaning unit and noted in the left hand column and in the right hand column a breakdown of the meaning unit was recorded. A meaning unit was often a string of text that expressed a single coherent thought. An example of this can be seen in Table 3.6. These became theme phrases or theme statements (Step 4)

Meaning unit	Participant response	Breakdown of meaning unit
cost	Especially cos on the block placement too, you only really have the weekends to do your part time work, and if you're driving a far distance you've gotta pay for fuel, you've gotta pay for parking so you have that opportunity to go and do your part time work as well but you're also tired, cos you're working five days a week and then on the weekend doing your part time work, whereas like I was saying we have those gaps to be able to sort of have that break, go off and work and sort of make our living.	Balance between paid employment with uni commitments

TABLE 3.6 EXAMPLE OF IDENTIFYING MEANING UNITS

Step 3: Group patterned meaning units

Recurring meaning units were identified and recurring meaning units were grouped together. This was compiled on an excel spread sheet each saved under the cohort for example 'synchronising academic data'. At this point the researcher returned to master transcript and re-read for sense, reviewing meaning units and revising as needed. An example of this is shown in Table 3.7.

Academic 1	Academic 2	Academic 3
Um, so as long as, and which we've done, or have made efforts to do that, make it much clearer about some of the limits to their self-rostering. You know, not all weekends, not, there'll always be one student who'll push it, you know, blah, blah, blah. Um, sustainable it's, it really comes down to the time table. Really. If – if we could fix that timetable so that you could guarantee that they had two or whatever. So it's – it's the limitations with the timetabling program that we have that make it hard for us. If we had a simple thing saying,	Oh, we need to keep the good relationships with the venues where we are doing it, I think we need to make sure that students are prepared for it, so that they... again that's part of our keeping the good relationships, if the students are well prepared and that, like, because if it's organised in such a way, or changes, that becomes a negative, then the students are not getting... it doesn't work.	Yeah, so that we can keep going with it because as you have already mentioned earlier, that we introduce it on the premise that more people, you know we wrote it into the curriculum with a premise that it is going to be the major focus of clinical and yet here we are in our third year of the curriculum and it's become apparent that isn't the case. So if we are going to continue with the current curriculum, how are we going to, you know, what ideas have you got there that we can keep the flexible model going, so that it is, you know, so that we can keep it moving forward?

TABLE 3.7 EXAMPLE OF GROUP PATTERNED MEANING UNIT 'SUSTAINABILITY'

Step Four: Generate theme statements

Once all the meaning units were clustered together, a word or brief phrase stating the meaning shared in all instances of the meaning units was generated. These words/phrases were basic theme statements. The entire master transcript was re-read with themes in mind to ensure accuracy. Theme words or phrases were revised to fit the overall meaning of the original meaning units. The master transcript was re-read with basic theme statements in mind to ensure accuracy. An example of this can be seen in table 3.8.

Quote	First Theme statement	Second Theme statement	Theme
So they have had sometimes false expectations of what it can deliver and just how flexible it can be. And you have got to be wary that there's no manipulation and no mixed messages going on with you know, what the students are expecting out of the clinical agency. So I think it's a bit more liaising .	united front between academics and clinical venue	student preparation for both unit objectives and hospital requirements	Preparation

TABLE 3.8 GENERATED BASIC THEME STATEMENTS

Step 5: Create tables or matrices of themes and meaning units

A matrix for each theme was developed in excel, showing all the related meaning units which exemplified the theme statement and a theme was identified. Each meaning unit was evaluated to ensure that the theme adequately and accurately captured its meaning. An example of this can be seen in Table 3.9.

Theme statement	Meaning unit	Meaning unit	Meaning unit	Theme
Having time to look at lecture notes	Bringing information back to uni, engagement in classroom	Students wait too long to put it into practice	Students performing tasks not yet prepared for	Reflection on practice

TABLE 3.9 MEANING UNITS

Step 6: Write out a summary of the themes

A brief narrative summarising the main issues being investigated was written for each theme, including that the theme statement adequately and accurately expressed their original meanings. An example of this final step may be seen in Table 3.10.

Theme	Summary
Balance	Balance was important to all participants but in particular to students. Being able to balance paid employment around university and clinical commitments was very important. The associated costs with clinical placed a burden on students both financially, socially and especially on family life.

TABLE 3.10 SUMMARY OF THEMES

Once data were coded, the reduction process commenced. There were 138 meaning units identified among all participants. These were reduced to 45 theme statements or phrases, which were further reduced to create four themes: communication, reflective practice, balance and commitment.

Limitations

It is acknowledged that this was a small cohort and does not speak on behalf of all nursing students, preceptors and nursing academics but rather only on those participants in this study.

Summary

Ethnography is a qualitative research method that aims to understand cultural phenomena reflecting a system of meaning and knowledge that guides the lives of cultural groups (Kimble et al., 2008). Data collection in ethnography is

carried out my means of observations and interviews of participants; data collection is done to capture ordinary activities and social meanings. Ethnography is helpful in social research (Hildreth & Kimble, 2006) and works well when researching communities of practice. This study focused on the learning of undergraduate nursing students of a particular community, the Flexible Clinical Education Model at Hospital X. Different views of people within a community were noted, strengthening the overall results. In this study, the use of ethnographic methods enabled the identification of four themes associated with student learning and practices.

Communities of practice theory supported ethnographic methods and provided a theoretical framework to understand the ways that students identified as nurses in clinical placements.

The focus of interest for this study was the clinical experience of undergraduate nursing students in a medical and surgical environment. The study was conducted in four wards at Hospital X, Victoria, Australia.

Fieldwork involved the researcher, attending the four wards once a week over a two month period. Fieldwork and participant observation was recorded daily in separate volumes of field notes. Additional data were obtained by interviewing informants and by collection of material documents to substantiate observation and to gain further insights into the clinical experience of undergraduate nursing students. Data analysis was conducted simultaneously with data collection.

CHAPTER 4

Findings

Introduction

In this chapter, the themes derived from the data will be explained in detail. The focus of interest for this study was the clinical learning experience of 19 undergraduate nursing students in a medical and surgical environment. As outlined in Chapter 3, the current study was conducted in four wards at Hospital X, Victoria, Australia. The overarching research question for this study was first presented in chapter one:

How can the Flexible Clinical Education Model allow nursing students' learning to be central and valued?

The four contributing research questions were also introduced in Chapter 3; this chapter addresses these four contributing questions.

The findings, drawn from rich ethnographic data, were obtained as follows: from interviews with the four individual academics, five preceptors; from three student focus group interview; from eight participant observation sessions undertaken by the researcher. The analysed data were clustered under four headings relating to each research question, as follows:

- Preparation
- Partnership
- Satisfaction (with learning)
- Sustainability

Themes

Many meaning units were derived from the data, which were then grouped resulting in the generation of theme statements, which were reduced further resulting in four themes; communication, reflective practice, balance and commitment (demonstrated as dark blue circles in figure 4. 1). Communication resonated with all participants, and the analysis resulted in this emerging as a major theme. This was not surprising, as, according to Scardamalia (2000), communities of practice in nursing and education include individuals engaged in the production, proposal and sharing of ideas and knowledge to advance their community. Communities of practice collaborate to co-develop knowledge about nursing or educational practices. The major and minor themes were differentiated, but interrelated, as demonstrated in Figure 4.1, and the explanation provided in this chapter will

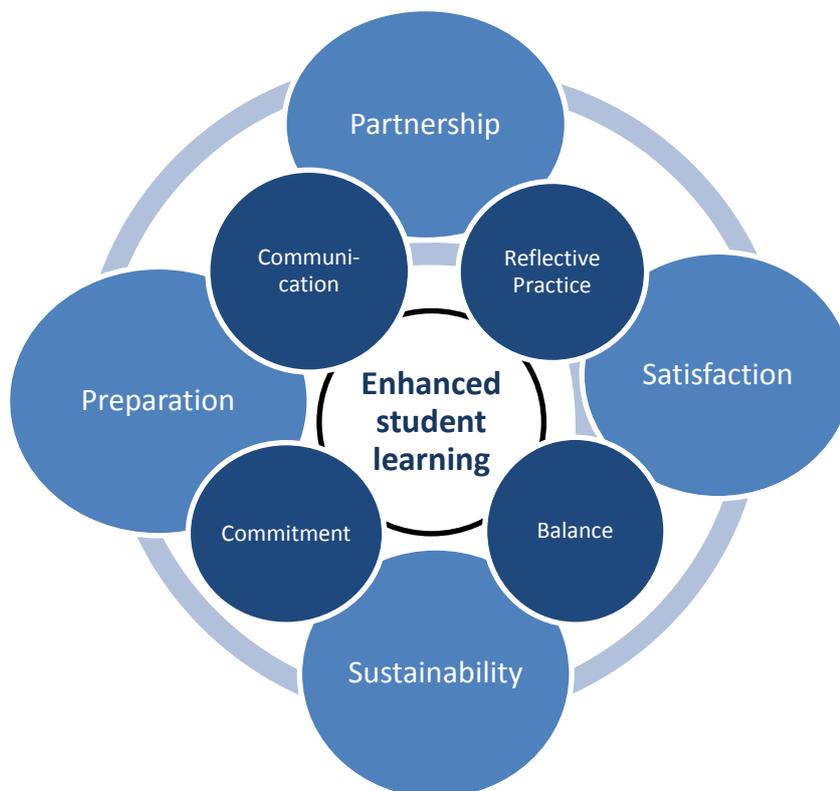


FIGURE 4.1 INTER-RELATION OF THEMES AND ENHANCED STUDENT LEARNING.

highlight the distinctive elements of these themes, together with their relationships.

Emerging themes

The themes emerging from the data; communication, reflective practice, balance and commitment are presented here so that an understanding of the contextual definition within the current study is ensured and comparisons with previous research are facilitated.

Communication

Communication, the major theme, incorporated many sub themes that described the participants' experience and the researcher's observations of how information was passed on between the groups. The Macquarie dictionary states that communication is 'the imparting or interchange of thoughts , opinions, or information by speech, writing or signs' and 'the science or process conveying information especially by electronic or mechanical means' (p. 365). Early communication researchers, such as Hymes (1962, 1964) as cited in Johnstone (2010) used ethnographic methods to seek answers to the 'why' and 'how come' questions, often immersing themselves to observe a particular social group. Johnstone (2010, p. 4) continues by suggesting that communication is more than simple transfer of information, but states 'speakers of a language in particular communities are able to communicate with each other in a manner which is not only correct but also appropriate to the sociocultural context'. The findings that support communication will be presented under the research questions, that is: preparation, partnerships, satisfaction, sustainability all of which contribute to enhanced and student learning and are noted in Figure 4.1 as light blue circles (pg 73).

Reflective practice

Reflective practice is the first minor theme that all groups acknowledged was a constructive component of the Flexible Clinical Education Model. The extended time provided students with an opportunity to reflect on their learning and practice. Broad frameworks for reflection on practice have been offered by founding theorists such as Benner & Wruble (1989) in nursing, and Schön (1983) in education. It is Schön's definition that has most salience with the findings of this study: he suggests that reflective practice is the ability to consider actions for continuous learning to occur that is reflection in action. Nurses are constantly encouraged to be reflective practitioners; many scholarly articles have been written about reflective practice in nursing (Burns & Bulman, 2000; Taylor, 2000; Rolfe, Freshwater & Jasper 2001; Somerville & Keeling, 2004). It was seen from the data that the Flexible Clinical Education Model provided students with the opportunity to become reflective practitioners. Findings from the data, which validate students' received opportunities to reflect, are also presented later in this chapter and will be discussed in relation to the research questions about preparation, partnerships, satisfaction, sustainability and their impact on enhanced student learning.

Balance

Balance was the second minor theme that was particularly important to the students. However, other participants also commented on the value of this theme as contributing to student learning. There are multiple definitions of study and work-life balance, with balance being achieved in different ways for different people. In its broadest sense it is defined as having 'sufficient control over where, when and how you work to fulfil your responsibilities within and outside paid work' (Royal College of Nursing, 2008, p. 3). The findings revealed that the accommodating nature of the Flexible Clinical Education Model enabled students to find a manageable level of balance during their

clinical practicum. A discourse of these findings will be presented under the research questions; preparation, partnerships, satisfaction, sustainability and student learning

Commitment

Commitment was the final of the minor themes that emerged from the data. All cohorts identified that commitment was a significant factor that affected the motivation and willingness to participate and learn. Undergraduate nursing students have to be committed not only to the Bachelor degree, but also to working unpaid shifts over evenings, nights, weekends and holidays. These commitments often affect student learning at university. The data from the current study revealed that students and staff were committed to the Flexible Clinical Education Model, which had a positive impact on students' experience. The findings revealed there was a commitment of preceptors and academics to work in productive, collaborative and professional ways.

The findings will be presented in terms of the research questions relating to preparation, partnerships, satisfaction, and sustainability and their impact on student learning. The findings for each research question are presented with evidence and discussion of the four themes: communication, reflective practice, balance and commitment. This can be see in Figure 4.2

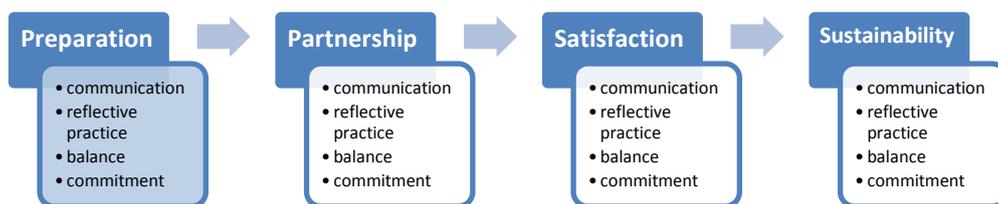


FIGURE 4.2 RESEARCH QUESTION AND THEMES

Preparation

This section relates to the research question: How can the Flexible Clinical Education Model assist students, academics and clinicians to be well prepared to meet the objectives of student placements?

At the time of the study the Flexible Clinical Education Model preparation commenced well before the initial clinical placement. The Clinical Learning Office was required to submit student numbers and requests for clinical placements 12 to 18 months in advance, which clinical venues either accept or decline. Once all placements had been filled, the Clinical Learning Office began a process of allocating all undergraduate nursing students to a clinical venue suitable to meet their learning objectives. This was assisted by close liaison with a relevant Clinical Unit Coordinator. The process for allocation was the same for both the block model and the Flexible Clinical Education Model. Once allocations were complete, the Clinical Learning Office provided each hospital with a list of student names, the name of the clinical teacher (if required) and expected dates of each placement. The wards at each of the venues were then informed of these details.

Academics were required to prepare students for their upcoming clinical placement. This included ensuring students had the required theoretical knowledge to ensure they practice at a safe, competent level. Students were required to have all mandatory paperwork submitted to the Clinical Learning Office prior to the first placement of each year. This included a valid police check, current working with families check, up-to-date immunisations and a signed fitness to practice document. If any of these documents were out of date or not presented student placements would be cancelled.

The evidence gleaned from the data will now be discussed to indicate the importance of the four themes – communication, reflective practice, balance and commitment – in effective preparation for clinical placement.

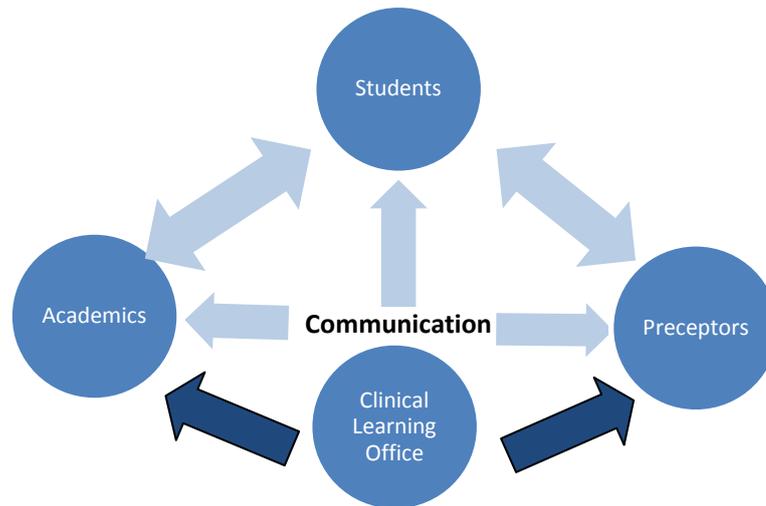


FIGURE 4.3 COMMUNICATION AND STUDENT LEARNING.

Communication

Communication between academics, students, preceptors and the Clinical Learning Office was an intertwined and vital component of student learning. Figure 4.3 depicts the channels of communication required for enhanced learning (light blue arrows) to occur. The data revealed that communication direction was often absent, ineffective or one directional (dark blue arrows). Students, academics and preceptors all commented that communication was often unclear or absent. This was also noted during the researcher's participant observation sessions.

The significance of communication with respect to preparation is presented below, commencing with data gained from students, academics, preceptors and during the researchers observation sessions.

Students

Students require the necessary educational preparation and knowledge to face real scenarios. This did not always occur, with one student (Focus Group 1) commenting that she did not feel the lectures matched up with what she needed during clinical practice, ‘the classes didn’t suit the placements so yeah, they were different kind of topics’(FG 1). From this comment it was clear that the academics and preceptors were not communicating the learning opportunities required for students.

The focus group interviews indicated that there were many cases where students had no clear idea about what they were supposed to do, or how the Flexible Clinical Education Model worked. They had not been suitably prepared or instructed by the academics or the Clinical Learning Office. This is evident in the following assertions:

It was only during orientation that we got to know what was expected (FG1).

I thought the flexible model meant we could come and go as we wanted; you know, start later or finish earlier (FG3).

Yeah, I didn’t know about all the rostering rules and stuff (FG3).

Students claimed they were not told exactly what they were supposed to do in the clinical environment. When asked if they had checked on webct for electronic copies of the unit guide, only one out of nine students admitted to looking at the clinical unit outline for information relating to the clinical unit. This lack of clear communication made learning difficult for the students. Academics have a responsibility to prepare the students for different medical scenarios, health issues and medications in which they will require to function in the clinical arena. From the interviews it was apparent that

academics had in fact uploaded all the required information for students, but this message was not received clearly or acted upon by the students.

Clear communication between academics, preceptors and students ensures excellent preparations, making the most of the Flexible Clinical Education Model learning environment. This was particularly important for students engaged in the Flexible Clinical Education Model, particularly as they commenced their placement early in the semester. Information overlooked or missed, placed students behind with their placement preparation.

In the Flexible Clinical Education Model, students had the opportunity of attending clinical placement across all three shifts and over weekends. This required students to complete a roster that ensured equal distribution of shifts per student and ensured the hospital was aware of which student would be attending on any given day. Students seemed most concerned about how the rostering of shifts was allocated. This minimised their flexibility to work, life and study commitments. Comments such as the ones below resonated through the three focus group interviews:

Sometimes the roster was put out when you're on days off, so when it comes to you it's already filled up, so you just don't have the flexibility (FG 2).

When the roster comes to us it's already filled out. We have no more choice (FG 1).

I put in for Monday, Tuesday, Wednesday every week but it didn't work out that way because there were so many students that have to go through (FG 3).

Once students understood the principles behind the rostering, most commented that it was a good process and one that allowed them flexibility during the placement, as well as preparing them for the 'real world' when they graduated. On the other hand, most students participating in the focus group interviews for this study did not request to be part of the Flexible

Clinical Education Model, and negative feelings were expressed towards being selected for the model during the focus group interviews:

Well, I put in my preferences and obviously didn't get it, and now I had to come here (FG 1).

I just called up [the CLO] and I was like, oh, ok, wait, wait, I didn't put down for this (FG 2).

I didn't choose any of my placements, actually (FG 2).

These student comments indicate a lack of communication between the Clinical Learning Office and students. It was interesting to note that one of the very vocal students who claimed to have been unprepared for the Flexible Clinical Education Model (that is, she had not chosen it, nor did she know much about how it worked) thoroughly enjoyed her placement and would recommend the Flexible Clinical Education Model to other students:

I was a bit annoyed because I wanted to get all my blocks over and done with so I'd have longer holidays. But um, it's turned out to be a blessing in disguise I think, because, I can work still and earn money. Cause it's really, that block, that month that you're not working, it's really hard when you have things to pay off and stuff like that. So I would actually recommend, like, if I had to choose again I would choose flexible, cause it's not so stressful (FG 3).

It was apparent from the interviews that the level of communication was such that the students felt underprepared for their clinical placement. As a result, this affected their ability to coordinate their clinical placement with other commitments, and impeded the early learning experience.

Academics

In the current study, academics were the educators who teach undergraduate nursing at Victoria University. They were mostly involved in giving lectures and providing tutorial and nursing skills laboratory sessions. All the academics interviewed were either coordinating, or had in the past coordinated, a clinical unit of study.

The first issue raised by academics was the lack of preparation for the Flexible Clinical Education Model. Even though all academics had previous experience as a Clinical Unit Coordinator, they agreed that they felt inadequately prepared for this role. Academics provided the fundamental preparation needed to ensure that the students were prepared for practice in clinical environments. They also provided laboratory based or simulated learning environment education. Overall, they were responsible for teaching the different theoretical and practical aspects of nursing.

One academic received no communication from the Clinical Learning Office was not even aware students from her unit were in the clinical environment until after the students had commenced:

I hadn't appreciated that they were actually doing this [clinical] whilst they were still in class, and my vision of that pure version of the flexible was that they're not competing with lectures and tutorials, that they'd be out there in a block period, but self-rostering with their buddy over a period of time. I didn't realise until this year that, well actually they started in week 2 (Academic 2).

This academic was not alone. Other academics had similar experiences. It became apparent that communication from the Clinical Learning Office had not provided clear guidance to academics about the expectations of the role. This was evident in the reflection of one academic (Academic 4) who asserted 'I felt a little bit out of touch with how exactly it was going to work'. Once this academic became aware of the expectations of Clinical Unit Coordinator, he was able to quickly establish how to move forward:

It just kind of meant that I had to get myself into the information loop that was happening through the clinical learning office, particularly the partnerships coordinator. And once I was up to speed with that, I thought that was okay (Academic 4).

Other academics experienced a similar situation to Academic 4, where they identified an uncertainty about their role; however, all could see how improvements could be made through appropriate communication from the Clinical Learning Office. This is evident in the following extracts:

But I think as more and more staff become more familiar with it, the problem will be less. It'll filter through as well, 'cause at the moment, there's only four staff that have actually coordinated the unit that have had the flexible model (Academic 1).

You know I had the idea of the flexible model the students go on two days a week or whatever, but there was a lot of kind of rules and regulations that were being made between the agency and the clinical learning office, that I wasn't in touch with all the detail (Academic 3).

I sort of had to learn it as I got along. Because unless you coordinate a clinical unit, why would you want to know about clinical. But it's in place now and I think I understand it better (Academic 2).

When clarification from the Clinical Learning Office was sought, academics were directed to the local server where abundant written information was available. Academic 2 offered this valuable insight on how to address this issue:

Maybe we devote a staff meeting at some point about discussing flexible. Where you [Clinical Learning Office staff] have got the entire floor, you have got the entire staff and we can discuss it and people's understanding demystified (Academic 2).

Communication between the Clinical Learning Office and academics was essential to ensure students were well prepared for the clinical environment in both theory and practical skills; in particular, clear communication was needed to understand the principles of the Flexible Clinical Education Model. It was vital that academics were able to teach the different theoretical and clinical aspects a nursing student would be expected to do when on placement.

In the interviews, most academics complained they felt underprepared on the many different aspects of the Flexible Clinical Education Model and did not have a full understanding of the practicalities involved. There was a lot of confusion relating to class scheduling, student responses and instructions from the Clinical Learning Office. It was clear from the interviews that academics needed to be provided with a clear and organised educational plan,

to help them prepare students effectively. However, this did not create communication gaps that compromised the teaching of academics and the learning of students. Without exception, all academics acknowledged that when they realised they were underprepared, they sought help from the Clinical Learning Office, who provided them with the support and information required. It can be noted from this experience that academics require preparation from the Clinical Learning Office in a more timely and thorough manner.

It was clear that, while there was a vast amount of information available to the Clinical Unit Coordinator, it was not being accessed or used. Once staff were aware of the available documentation, the process involved with the Flexible Clinical Education Model was easily able to be followed; this included being aware that attendance at each orientation was highly recommended.

Preceptors

Preceptors are individuals who are involved in providing practical supervision in the clinical educational environments; they are registered nurses, and communication is important for them. They are central to inward communication from the university and outward communication from the hospitals.

The preceptors in this study were responsible for the supervision of practical education in the nursing environment. Practical experience is unlike laboratory based education: it provides a learning experience with many variables. In the laboratory setting, variables are closely monitored and controlled, to ensure students have a near to perfect experience; however, in the clinical environment the variables are difficult to predict and even harder to control. In the clinical environment students apply the methods and techniques learnt during theoretical classes; the preceptor must be able to understand what the students have learned. In this case, the preceptors

assisted students with putting theory into practice, but could only do so with an adequate knowledge of what students had learned at university.

From the interviews and participant observations, it became apparent that many preceptors were faced with challenges because they believed students had not been taught the basics of nursing care. There were communication gaps between the students and the educators: students informed the preceptor they had not yet covered a topic; this frustrated the preceptors who would then spend time going over what they considered basic nursing skills. The preceptors asserted they were wasting precious time on the ward:

They definitely needed help along the way...they're not up to scratch and I don't think that's our role, to do that (Preceptor 4).

I had one that couldn't do a nasogastric, imagine coming to a neuro ward not knowing that (Preceptor 1).

The academics in this study disagreed with this viewpoint: it was clear that the students had in fact covered the skills at university; there was no apparent explanation for the student being unable to perform the task. Written, verbal and demonstrable communication between academics and students was paramount to all; academics and preceptors agreed that students needed to have a sound theoretical knowledge to gain competence during placement:

It is important that what they are doing here [university] is relevant to what they will be doing on placement, without it they are flying blind (Academic 2).

Preceptors felt there was inadequate lead-up time to the clinical placement. While preparing for student clinical placement, the preceptors were often unaware of student learning needs until they commenced the placement. One preceptor noted:

I never knew what was expected of them, I was never sure if they needed to be supervised or how many patients they could take. When I asked them [students] they didn't know either (Preceptor 1).

This was particularly evident with the night duty staff who had not attended the briefing sessions held between the university and hospital (these sessions were held during the day when they were not at work):

Yeah definitely more information. I didn't know what was expected of them, so probably, a little bit more education for the girls that will be on nights and having them would be good (Preceptor 3).

However, night duty staff noted that students 'were like a breath of fresh air' (preceptor 3) bringing new ideas, promoting new learning from experienced staff.

From the preceptor interviews it became apparent that adequate written communication regarding preparation for the Flexible Clinical Education Model from the Clinical Learning Office and academics prior to the placement would ensure preceptors were prepared for the arrival of their students so that learning might commence from the first shift.

Reflective practice

According to Plato, 'the unreflected life is not worth living' (cited in Taylor, 2000, p.10). While reflection is a component of critical thinking and an essential part of problem-based learning, reflective practice is being used as a teaching and learning model in many nurse education programs for the development of critical thinking by students. Many graduate nurses also continue to use reflective practice as a method of critical thinking for their professional development.

Clinical practice is an important part of nursing education. In the Flexible Clinical Education Model, practice plays a vital role and there were several participants involved in this model. Data gleaned from individual and focus group interviews provided an understanding of how participants were able to reflect on their practice in the Flexible Clinical Education Model.

Theoretical knowledge is required for students and they were aware of the importance of applying theoretical knowledge to clinical practice. It is important for all students in the health care system to have practical

experience in the profession prior to their entering. In the focus groups, students showed awareness that situations must be dealt with in a professional manner. Students observed members of the health care team and commented on the interplay of other professionals, increasing their awareness of hospital dynamics:

It was good to watch the relationship with the multidisciplinary team like the doctors and physios; it helps to build a respect for the other person's position (FG 1).

Watching how experienced staff managed difficult situations enabled students to reflect on their own practice. Students could then imitate this observed behaviour:

Yeah, once I knew who I had to call, I was like, oh this is good practice for next year (FG 3).

Students commented on their inability to perform certain skills in the hospital setting, even though they had completed them in the skills laboratory classes at university. It was interesting to note that students were reflecting back to the nursing skills labs, where they had confidently performed certain tasks, yet when asked to complete the same task in the ward they fumbled. One student (FG2) commented, 'I was even nervous making a bed! You know, worried I wouldn't get the corners right'. The students acknowledged they did not really consider the importance of adequate preparation before they attended clinical practice. Most agreed they thought they would learn it on placement with one student reflecting she did not feel she had adequate preparation:

Sometimes I needed to ask someone how you do a lot of standard work. I just didn't know (FG 3).

There are many factors related to preparation of clinical placements, and all of them must be considered when preparing students. Academics reflected on previous unit coordination to develop a sense of what is required for the current unit coordination. They agreed that practical education was provided in such a manner that each and every student acquired adequate knowledge

prior to attending clinical placement. It was noted that the time frame was not clearly set out by academics so that each student could attend the practical sessions without affecting their theoretical classes. Each semester, the three theory units were structured to enable students to have two free days each week from university. One academic commented this was a new process for her:

Well, I guess in midwifery we have probably been doing flexible for a long time but not under the banner of the flexible model. So I guess I understand it from that point of view; but this year in particular, it impacted on me because we had to make sure that particular lecture days were kept free so that students could attend their clinical (Academic 2).

In the interviews, academics commented that, in the Flexible Clinical Education Model, timetabling was crucial. It was vital that students had the minimal set of necessary skills by the time they commenced clinical practice. The students often commenced the Flexible Clinical Education Model by week three of the semester, so the academics constantly stressed the importance of practice to them; the academics noted that, from commencement, the students were encouraged to start reflecting on their own practice in preparation for the Flexible Clinical Education Model. Academics commented they encouraged students to picture themselves in the clinical environment, asking them if they were ready, or what they might need to improve. Without exception, all academics acknowledged they should have known more about the Flexible Clinical Education Model when agreeing to coordinate a clinical unit of study. Some academics thought they had a good understanding of the model, but when the time came to coordinate the clinical unit, issues arose that they had not considered:

I had done a lot of preparation for the flexi but when I got my first call in week 5, I thought ‘shit, how can I sort this out when I am teaching all day’ (Academic 3).

From the data, it was noted that all academics reflected on their previous experience; however, if they had not previously been involved in the Flexible

Clinical Education Model, there was a void of knowledge that needed to be filled. It was only when faced with uncertainty that the academics became aware they required more information to be able to competently carry out their role.

Reflection on practice is integral for students to gaining competence in any given situation. Consideration on the situation, time, place, participants, activities and history are needed to reflect upon practice. According to the Australian Nursing and Midwifery Council AMMC, 2005, p. 2) Code of Professional conduct for Nurses in Australia: ‘A nurse is personally accountable for the provision of safe and competent nursing care. Therefore, it is the responsibility of each nurse to maintain the competence necessary for current practice’.

It can be seen from this that preceptors are responsible for reflecting not only on their own practice but also ensuring the delivery of safe and competent nursing care. They must act responsively to the students at all times:

...when watching Sam* do a dressing I noticed that she had touched the sterile field so I had to stop her’ (Preceptor 1).

From the participant observation (PO) data, it was evident that assessment was being performed continually. When students performed a task for the first time, preceptors provided feedback about the knowledge and practical performance. At one participant observation session, I witnessed a student nervously provide a handover of her patient:

It was actually more of a conversation between the student and the registered nurse, it was very informal, it was at the end of the patient’s bed and it was a backward and forward conversation. The RN admitted that when she first heard a lot of the terms in handover she wasn’t sure what they actually meant and the student was reassured by this, she said “Oh that’s a relief, I thought it was just me” (PO2).

When these skills were repeated, the preceptors encouraged students to think about their previous experience and make necessary changes to their practice. Preceptors and students often followed up on previous tasks performed, reflecting and reviewing the procedure and the related rationale.

Balance

Balance is an important theme emerging in the perceptions and experiences of participants in the Flexible Clinical Education Model. It was necessary for all participants to ensure students' learning needs were met; encouragingly, this was strongly affirmed in student comments. It was important for each student to balance clinical placement hours with theoretical learning, paid employment, and home and life commitments. There were two main components of balance relating to communication that students discussed: first, students required timely information to work effectively in clinical situations; second, students wanted to balance their course requirements with their personal commitments. Data obtained from this study suggests that the Flexible Clinical Education Model enabled this to occur.

Students felt the Flexible Clinical Education Model allowed them to learn about theory and then apply this new knowledge in the clinical environment, often within the same week. Students commented that this balance was important: students who learn theoretical methods today will be applying those methods in real-life situations in various nursing homes or hospitals with the methods still fresh in their minds. Preparation is paramount to ensure the theory balanced the practical experience.

Students commented that balance was also necessary to fit in university commitments with clinical placements:

It was good to be able to work out my schedule around uni stuff. Having the flexibility to roster myself when it suited me let me, you know, made it easier at uni (FG 2).

This was especially important around university examination time, where students expressed a desire to balance study with clinical time:

Yep, it was much easier like, you can request to not do a shift because of exams or assignments when they are due (FG 1).

We also have a bit of control over what we want, like for example, I didn't want to do a lot of placements during my exam times...so from after the exams onward I'd be having a lot of days (FG 1).

Students compared themselves to other students who were not in the Flexible Clinical Education Model and empathised with the challenges they faced. We see this in a conversation made in a focus group session:

A couple of my friends had the full eight weeks in a row and they were really struggling with assignments and everything (FG 3).

All of the students who participated in the focus group interviews worked part time. Students commented that the flexible nature of the Flexible Clinical Education Model ensured a healthy balance between paid employment and meeting university requirements. The block models placed great restrictions on students often forcing them to work fulltime during the semester: this compromised their learning. Students spoke of the difficulties they experienced when undertaking block placement:

In a block placement you only really have the weekends to do your part time work...whereas like I was saying we have those gaps to be able to have that break, go off and work and make our living (FG 1).

It's hard in a block model as I have to work as much as I can to build up some money so then be able to live while I'm on my block placement (FG 3).

Balance was not just about paid employment; the financial benefits extended across balancing spending time with their family and still being able to meet university requirements. One student, who is also a mother, noted:

From my perspective as well, it's easier to juggle the family because there's not as much stress on them... the last block I had mornings all the time and so my kids were sleeping at Mum's house every night (FG 1).

Another student from the same focus group added:

Yeah, I've got three kids and if they went to childcare every day for that four weeks it costs a fortune and yeah I had to get my Mum here from South Australia (FG 1).

Most of the students felt under-prepared for clinical placement and found it difficult to balance their work commitments with clinical placements. They

commented that they had not been provided with ‘any information’ from the unit coordinator. Some students also believed they did not have adequate theoretical knowledge for clinical placements; however, this sparked debate within the focus groups: some students did feel adequately prepared. The comments from students largely hinged on lecture attendance and nursing skills laboratory practice. A few students admitted to not attending any lectures:

It’s just information overload at uni and then you come here and you’re trying to remember everything and it’s like ‘well I probably didn’t even attend that lecture’ you know (FG 2).

The Clinical Learning Office was the first place that students sought information from when seeking guidance in planning their clinical placement. Students were predominantly concerned with knowing when their upcoming clinical placement was scheduled. This ensured there was adequate time to provide their paid employer notice of their inability to attend work. The students were able to submit a preference form to the Clinical Learning Office, with a list of hospitals and dates that suited them. From this list, the office allocated students according to their preferences; however, many of the students complained that they did not get any of their preferences. This meant they were required to attend a hospital they had not chosen. Students complained most when placement dates did not match their preferred dates. Nearly all the students commented they did not mind going to another hospital, but that the dates were important.. This was because students had to balance their clinical placement around paid employment and family commitments.

Some students found the timing of a block model difficult. One student had had to repeat a failed unit; because of this, it had been over 12 months since she had attended the nursing skills laboratories. Another student commented that she completed the theory unit in semester one, but did not get the correlating clinical unit until the following February. This was due to a shortage of clinical placements:

Well you're not at uni for like five weeks and then you do a placement or then you don't have one for like six months...by the time you get to that you forgot what you've learnt (FG 2).

All students found the timing of the placement important; similarly, they all agreed that the Flexible Clinical Education Model enabled them to better balance their paid employment and personal commitments with their university requirements. Having the opportunity to choose when to complete their placement greatly assisted with this balance.

Academics were involved in the theoretical preparation of students at university, and aimed to provide a link between theoretical and practical knowledge. Three out of the four academics suggested the Flexible Clinical Education Model provided a greater opportunity to link theory with practice. Academics often used the Flexible Clinical Education Model in ways that assisted students in applying their theoretical knowledge in a practical situation. They then encouraged students to discuss their learning experience with others in class. One academic commented that balancing the delivery of theory with clinical experience 'enriched' the learning by bringing current experiences about relevant topics from the clinical environment to the classroom:

You are getting students doing a couple of days and coming back and talking and value-adding their clinical experience; a very recent clinical experience, sometimes coincides with the topic that you're lecturing about (Academic 3).

Working in the clinical environment was described as challenging. It was important for the interviewed academics that students were adequately prepared to work in the dynamic and diverse environment of clinical practice. Academics commented that it was necessary to plan their semester incorporating the Flexible Clinical Education Model into the teaching period. Once academics had coordinated the Flexible Clinical Education Model, they were able to plan their teaching commitments accordingly to balance their own working week.

There were several factors requiring balance when preparing the practical sessions, commencing with the preparation of the Flexible Clinical Education Model preceptors. Two of the preceptors were experiencing the Flexible Clinical Education Model for the first time. All preceptors attended the two hour meeting on the Flexible Clinical Education Model held at the university; however, one in particular, had a difficult time grasping the concepts of the model and her expectant role; she (P1) commented 'honestly that whole meeting went totally over my head... so for me that meeting was probably quite unhelpful' Later, she concluded more positively

Now I would say, definitely I think it wouldn't be a drama, I don't think there is anything that could present itself that I wouldn't either have an idea of or know how to resource (Preceptor 1).

Although completely overwhelmed at first, this preceptor commented she assimilated into the role and enjoyed the experience of being a preceptor for the students.

Preceptors were responsible for arranging practical experience for students in the Flexible Clinical Education Model. In the interviews, the preceptors noted how important it was to balance practical experience; it was suggested that the timings should be set after consulting with academics and students. The practical sessions were designed so that students had an opportunity to apply their theoretical knowledge in a real time environment.

Commitment

Student commitment to clinical placements is integral to nursing education . The nursing engagement is cyclic; this is often highlighted in real decision-making scenarios. Commitment to the Flexible Clinical Education Model starts with preparation from the Clinical Learning Office. When this office provided timely information to academics, hospitals and students, all participants expressed a stronger commitment to making the model successful; thus, clarity around their role was a necessary step for efficiency in their role.

From the focus groups, students who commented that they had chosen to participate in the Flexible Clinical Education Model provided evidence that they were more committed. Many of the students had not wanted to engage with the Flexible Clinical Education Model and had not put it down as one of their preferences. One student commented she did ‘everything possible to get out of it’ (FG 3). A lack of understanding was the main driver behind choosing the the traditional block model over the Flexible Clinical Education Model; however, all students who did not originally choose Flexible Clinical Education Model acknowledged that once they understood its principles they felt committed to making it work.

Theoretical learning is the first exposure to the nursing profession that undergraduate nursing students experience; this is provided by committed academics engaging in the delivery of theoretical study units. In some interviews students claimed that academics showed a lack of commitment towards their responsibilities. One student identified a time when an academic was clearly disinterested in the student’s learning, saying she ‘wasn’t interested in hearing about what happened on clinical’ (FG 3), and claimed that it wasn’t her ‘responsibility’. Students in the focus groups identified this was not a normal satisfactory standard.

Preceptors are responsible for the practical experience for the students: it is the responsibility each preceptor to be committed to the practical education of nursing students. At the same time, preparation for practical experience is a vital element of Flexible Clinical Education Model; in the focus group interviews, students suggested that some preceptors were not committed:

We were sitting in handover and they [ward staff] were arguing in front of us about who ‘wants’ the students. It was obvious that none of them did (FG 3).

When this was the case, students noted that learning was limited. Students often remarked that they would use a negative learning experience to highlight how they didn’t want to perform i.e., they took a negative learning experience and turned it into a positive. In the interviews, students said that those

preceptors who were not committed to their role created problems for students' learning.

All participants (students, academics and preceptors) agreed that preceptor training was essential. Students commented that the assessment process varied greatly between preceptors and this made learning challenging. One student commented that you had to 'get to know' (FG 1) your preceptor and perform the task 'their' way. Getting to know each preceptor's preferences was a challenge for students and they agreed that preceptor education would overcome some of these challenges if there was a consistent approach to teaching.

Without exception and despite the foregoing discussion, all preceptors commented that there was a deep connection with students in the Flexible Clinical Education Model model; this is evident in the following comment:

These are the students, they're yours. It's an ownership, and we own it. Whereas previously they were just coming in for two weeks and that is a visit. You feel responsible for them (Preceptor 4).

The preceptor's words above suggest that, for her, the level of commitment towards students in the Flexible Clinical Education Model was strong. The data revealed that the level of preparation and commitment of each preceptor affected student learning in either a negative or positive way.

The following presents the findings under the research question heading; Partnership.



Partnership

This section relates to the research question: How can the Flexible Clinical Education Model generate a genuine partnership between students, academics and clinical agencies.

As a practice-based profession, clinical education is an essential part of the undergraduate nursing curriculum. Clinical placements provide students with the opportunity to experience nursing in the real world and ideally enable students to put theory into practice (Elliot, 2002). It has been suggested that the success of nursing education is largely reliant on the effectiveness of the clinical experience (Pearcey & Elliott, 2004).

Kruger et al., (2009, p. 14) state partnerships are a 'social practice achieved through and characterised by trust, mutuality and reciprocity'. They are a fundamental factor in establishing solid foundations for future clinical education. The findings from this study clearly identify how the Flexible Clinical Education Model provides a foundation for establishing and maintaining a partnership between the university and health care provider, with student learning as the central outcome.

Historically, schools of nursing and midwifery have always relied on clinical venues for undergraduate clinical placements; without this nursing and midwifery degrees could not survive. This does not necessarily mean, however, that every university has a partnership with every clinical venue. In fact, partnership is unlikely if one or more of the three key elements—as outlined by Kruger et al. (2000): trust, mutuality and reciprocity—should be missing. The themes outlined below are drawn from the data and are tied to the importance of trust, mutuality and reciprocity in the construction of sustainable partnerships between academics and preceptors.

Communication

Partnership is an aspect of the Flexible Clinical Education Model model that is of utmost importance to students. In addition to this, collaboration is needed to enhance the learning of the nuances of nursing. This is not new. Since nursing moved into the higher education sector in the 1980s, the challenge for developing and sustaining quality clinical partnerships has been the number one priority for most schools of nursing. Most of the time students are unaware of this constant struggle to obtain adequate clinical placement.

The Flexible Clinical Education Model is accommodating and allows students to determine class schedules according to their convenience; however, the students need to work together to come up with a schedule that is convenient for everyone. Nursing students at Victoria University use an electronic platform known as ‘my c-learning’. This data base is uploaded each semester with student particulars, the clinical unit’s details, clinical venues and clinical educator’s details. This information can be accessed by the Clinical Learning Office, academics and students. Once clinical placement allocation has occurred, it is released to each student from this time, students have five working days to ‘swap’ placements with each other thus allowing students the opportunity to gain a placement that suits their time and needs. It is not always possible for this to occur; nevertheless, the system is in place to offer students the possibility to negotiate suitable placements.

This cooperation helps prepare students for the practical sessions in the Flexible Clinical Education Model: one of the first issues students encounter is rostering. Students need to work together to negotiate a suitable roster ensuring all students meet their clinical hours. The preceptor oversees this process, providing strict rostering guidelines, but essentially students are responsible for guaranteeing the needs of all students are met. In the focus groups the students commented on how, at first, the rostering was a challenge, but once they understood the requirements they worked together

to cover all the shifts: ‘We did our own rosters for three months so it was good you knew exactly where and when you were working’ (FG 3).

Some students even worked as a mini group, swapping phone numbers. This meant that if a student was sick they could ring other students to offer up their shift. This was a very productive arrangement that ensured no shift was left unfilled. The students all commented on how being responsible for their own rosters made them feel ‘like real nurses’. Most rosters were completed four weeks in advance (the same as for regular staff) which enabled students to prepare their clinical placement well in advance. Being listed on the staffing roster was significant and being seen as part of the ward was very important to the students: ‘Being on the roster was important because we could roster ourself with a preceptor we liked – you know, build up a relationship’ (FG 3).

Students relied on each other for swapping clinical placements, covering each other’s shifts and support. One student commented how on their first day they felt lost and unsure of where to go. Then they saw another student and, ‘I actually asked one of the students whom I’d not met before but, because they were in uniform, I could tell that they were a friend’ (FG 2).

Many of the students had completed previous placements as part of the Flexible Clinical Education Model. All agreed that this continuity helped build a strong partnership with the hospital and minimised the frustration of moving from hospital to hospital for each placement:

Because, especially if you have your placements, though, with different hospitals, you know, that’s another thing you have to get used to, the paperwork, where things are situated and all that kind of stuff (FG 2).

It was noted from the data that partnerships developed between student and student, student and preceptor and even student and facility. The Flexible Clinical Education Model strengthened these partnerships by providing the opportunity for each member to feel connected to each other.

One of the central aspects of the Flexible Clinical Education Model that relates to partnerships and communication was the orientation day. Students,

academics and preceptors first came together during orientation. It was here that a partnership was formed between all participants as they discussed the learning expectations in the clinical environment. Orientation is the first part of the clinical learning process, where the transition from the classroom to the real world occurs. The students are introduced to practical nursing and are initiated into the clinical environment. Here, communication is very important as the students get to meet the clinical professionals or registered nurses who will be supervising them during their clinical placement:

Orientation was good, it was the first time I really got to hear about how the flexible model worked (FG 2).

Meeting our preceptors before we started, was nice, you know, good to know who they were (FG 2).

The different members involved in the Flexible Clinical Education Model system interacted and met, often for the first time, during the orientation. Communication is important at this level so that students understand what is expected from them. Students expressed their satisfaction when noticing the Clinical Unit Coordinator was present at orientation, 'I was surprised to see Claire* at orientation, I'd never seen anyone from uni at other orientations' (FG 1).

Some students were not even aware of how the Flexible Clinical Education Model worked. It was evident that even after orientation students felt many questions were still unanswered. From this it can be seen that communication from academics and the Clinical Learning Office is needed to ensure the students are adequately prepared for their clinical placement and that they have the knowledge required to face a real nursing environment.

Academics need to partner up with health care professionals to provide a clinical learning environment for students. The academics interviewed described their interpretation of a partnership, based on communication between themselves and clinical agencies, 'I think there's certainly been a lot more communication with the flexible model educators than with clinical teachers' (Academic 1).

There was hope that the Flexible Clinical Education Model would be able to establish stronger partnerships:

...with clinical staff out there and academics and I am looking at I guess particular people; probably it fosters a much closer relationship because you have got to work much closer together to make sure it works (Academic 2).

All academics agreed that partnerships with an agency would be beneficial for student learning; however, it was acknowledged that this was initially labour- and time- intensive. When the Flexible Clinical Education Model was initially trialled, one academic was allocated to set up and oversee the running of the model. This position required particular kinds of skills for that academic to work with agencies in collaborative and supportive ways, taking the pressure off other academics having to know much about the intricacies of the model. When the Flexible Clinical Education Model became part of the curriculum in the Bachelor of Nursing, all academics became responsible for the communication and collaboration with external agencies. This was a new and often unexpected addition to the Clinical Unit Coordinator role. As one academic identified, 'I certainly communicate a lot more with the overall coordinator at the agency' (Academic 4).

One academic was uncertain as to whether there were any direct improvements with communication, due to confusion surrounding who to contact at the clinical venue, 'I seem to be more in touch with the block model in that there's a name, I know who's looking after them' (Academic 3).

Academics discussed trust across a number of different topics. It emerged that trust was a key issue with academics. It was not possible for them to personally oversee the clinical experience of the student and they needed to be assured that the clinical venue and clinical educator were informed of their roles and expectations. Meeting the CFs on orientation and during clinical workshops at the university provided academics with this comfort:

That's a clinical teacher that I know really well, who knows me really well, yeah, it's as much as... I guess, you can say that they are like a colleague, rather than being just sort of a sessional that you only see infrequently (Academic 1).

Also:

...that with clinical staff out there and academics and I am looking at I guess particular people, probably it fosters a much closer relationship because you have got to work much closer together to make sure it works (Academic 2).

While all academics agreed communication between university and hospital increased, it was their opinion that this was a positive aspect of the model:

There has to be a lot of communication and close, a closer relationship than the actual implementing at the beginning of each one at orientation and obviously ongoing. Because I see that there is a lot of respect between us and them out there. So I think there has to be closer liaison (Academic 2).

Nurses are professionals and are educated to perform the four main functions of nursing: care, administration, teaching and research. Academics initiated the partnerships between students and preceptors to introduce practical, real world scenarios to nursing students. They aimed to provide students with knowledge so they were capable of performing well in the clinical environment. The partnerships between academics and students are based on education and knowledge. The efficiency of a nurse depends on the education derived from this partnership:

We can give them theory and sims [simulated learning] but its only when they get to clinical that they really can connect the dots, so it's about trying to meet the students' needs with the best model (Academic 4).

This education is strengthened with hospital partnerships. Various studies have suggested that not all practice settings are able to provide nursing students with a positive learning environment. Chan (2004) concurs that to maximise nursing students' clinical learning outcomes, there is a need to examine the clinical learning environment.

The literature is inconclusive about the relative advantages of any one clinical education model (Elliot, 2002; Chan, 2004); however, it is clear that models provide quality learning environments where they involve genuine partnerships between clinical agencies and the university, where student learning is central and valued and where academics and clinicians are well prepared to meet the objectives of student placements. It can also be seen from the findings of this study that academics required skills and resources to create and sustain successful partnerships.

Considerable ground work was required to foster a partnership with hospitals; the interviewed academics commented how they often used their ‘clinical connections’ to gain student supervision. One academic commented that her daughter is a Nursing Unit Manager in the emergency department at a large public Melbourne hospital and she had approached her to gain a ‘foot in’ with student placements. Other academics commented that this early ground work was essential with hospitals and that early preparation was vital for the success of the partnership:

A lot of the work had already been done but it was the ironing out of the issues that arose that was important. Once we had established the relationship with them, we still needed to work hard at keeping it going (Academic 2).

Academics and preceptors noted it was vital that once the early preparatory phase had been established, it was just as important to continue with collaborating in building and maintaining the partnership with clinical venues. For the partnership to be maintained there needed to be some sort of co-operative interchange from the university. Most academics commented that this could be in the form of hospital preceptor education, a notion that was widely accepted:

We need to support the clinical hospitals... I think we have a responsibility in partnership with the hospitals to educate the staff and give them ongoing support (Academic 4).

Offering this ongoing support helped create a professional partnership that

fostered a sense of goodwill. This ultimately led to a more cohesive and more positive learning environment. The data has shown that all academics agreed that the initial groundwork for establishing a partnership had been completed when the Flexible Clinical Education Model was first trialled. Without exception, all agreed that while this had created a strong partnership, it was vital to continue strengthening the association. This would ensure a collegial and constructive environment was maintained, guaranteeing an optimal learning environment was achieved.

From the interviews, it became clear that the academics were required to attend orientation based at Hospital X. There was mention that attending offered support for students in their transition to the nursing environment. It was at orientation day that academics met with clinical preceptors and students who would be attending the clinical placement. The orientation commenced early in the semester, usually in week two, and each year level's timetable had been structured to enable students to attend this day. All year level lectures are timetabled for a given day. On orientation day they are pre-recorded and uploaded via lectopia, allowing students to review the content of each lecture at a more suitable time.

Data findings from the interviews also indicated that the presence of academics facilitated communication between students and preceptors. Academics communicated with preceptors to provide them with information about student learning and expectations; their presence made the students feel that the educators and preceptors were working together to teach them.

Academic staff realised the importance of attending orientation and that it was more than just meeting the clinical staff who would be providing clinical supervision for the students. Each academic noted that orientation allowed communication to occur between the academic, preceptor and student: this is clear in the reflection of one academic who notes:

So you get to know them and get to meet them at that point as well...we know what information the students have been given as well. So if there is any queries about the unit, you can be there to provide that instant feedback as well, that's good (Academic 1).

It was important for preceptors and academics to be seen as a united front. The orientation session provided a public forum for this to occur and one academic asserts:

I think it is helpful for the clinical educators, in that the students can see that the unit coordinator and the preceptors are working together as well, so that they know, the students know there is communication among them (Academic 2).

There was also a sense that attending orientation established a common ground between students and academics:

I've had a little bit of input into the orientation day and the types of things that are covered on orientation. And in doing that, the kind of changes that needed to happen seem to be, putting parameters around so it could work properly. I think the students had an idea about what flexible clinical learning was and the organisation had a different idea - there was a bit of disparity there (Academic 3).

Attending the orientation strengthened the partnership between university and hospital:

I got to see, hear what they say to the students, what their expectations are, the rules. I could also contribute, like a few times got up and clarified things based on the students' questions that they were asking there and then. I was able to answer some of those questions and the hospital couldn't and I got a sense they appreciated that I was there... talk through some of those issues and also flag very early what the potential problems are probably going to be with the self-rostering... because of the nature of some of the questions the students asked. I know what they're doing and so we were able to try and nip things in the bud there and then. So again, that was a bit of a discovery thing... we learnt a lot from that process (Academic 4).

It was important for the academics to communicate with each and every student present at orientation, discovering their strengths and weaknesses. The academics became aware of how important it was to discuss the different factors associated with the Flexible Clinical Education Model with the preceptors as well as the students. In opening this dialogue, students were

able to understand the varying aspects of the Flexible Clinical Education Model and the academics' and preceptors' roles in their learning.

Orientation day cemented the partnership between students and academics. From the focus groups, students commented they felt supported and more positive with the academics being present at orientation. This showed the academics and preceptors were working together, forming a team to help students learn:

I think it is helpful for the clinical preceptors in that the students can see that the unit coordinator and the educators are working together as well, so that they know, the students know there is communication among them (Academic 2).

This was beneficial and created a positive learning environment. Interviews with preceptors also showed that the preceptors liked the presence of academics, as this made them better equipped to deal with the students:

It's quite beneficial, because you can't have them [students] saying that they weren't given this information because there's been someone from the university that was there and also you know what the people from the university were covering in orientation too (Preceptor 2).

Preceptors taught students how to manage different kinds of patients and medical scenarios. The students got to work with patients in hospitals and health care centres. The partnership between preceptors and students was based on the preparation to take on real cases. Preceptors worked closely with academics to make sure that students were prepared in theory and practice, so that they had nursing knowledge to work in a clinical environment:

...I think initially when we were first starting out...it was new to everyone and it was very, very rushed in organising and preparing for the students, and actually preparing myself. But since then we've had more time and the liaison that's developed, with the university over time. I think that's really helped in better preparing (Preceptor 2).

The preceptors agreed that they must be present at orientation day to provide students with an understanding of how placements unfolded, as well

as the expectations of student learning experiences. At orientation it was vital that preceptors understood the education level of students, so that they might plan their teaching regime accordingly. From the interviews, preceptors believed that orientation allowed them to interact with the students in an informal manner prior to the first shift. It enabled preceptors to provide students with a clearer idea about the students' placement preparation.

In some interviews, there was a communication gap between the preceptors, academics and the students where information had not been received or was insufficient. It was noted that orientation day provided the opportunity to ensure all members were equally informed:

It [orientation] gives the students the idea that it's a united front, as such, but it also gives the unit staff the opportunity to step in and say something if we are giving the wrong information (Preceptor 1).

In most cases, the timing of the practical experience is determined by the university, according to the course structure. The preceptors felt the timing of the orientation needed to be communicated to them as soon as possible – so that they had time to prepare for student arrivals. This was more crucial during the early phase of the Flexible Clinical Education Model:

Initially when it was first starting out and it was new to everyone it was very rushed in organising and preparing for the students, and actually preparing myself (Preceptor 2).

This was further supported by the Nursing Unit Manager of one of the surgical wards, who commented:

I think they're able to focus more, because they've got a bit more continuity; we can allocate them to, to match their workload... as far as orientation goes in preparing them, and enabling them to expand their knowledge base, it's giving them a bit more insight into what the ward area actually is like (NUM 2).

The preceptor-student partnership determined a student's efficiency. The practical experience students gained in the Flexible Clinical Education Model system relied on this partnership. Preceptors and academics formed a

partnership ensuring the students were well prepared in theoretical and simulated practical classes, so that they performed well with the preceptors. The partnership helped synchronise the theoretical classes with the practical experience sessions so students could implement in real life what they had learned at university.

All preceptors acknowledged there was room for improvement; however, they were happy with the way the partnership was developing. All agreed that a well-organised orientation provided a solid platform, where students had the opportunity to view academics and preceptors working together in a professional and collegial manner.

Reflective practice

Reflective practice was an important part of the learning process. Students met the academics and Registered Nurse who were preceptoring them in their placement at orientation: it was during orientation that students were able to get a better understanding about how they were expected to behave. Preceptors modelled their expectations by being punctual, wearing correct uniform and being appropriately groomed. Students observed this behaviour and were able to reflect on their own appearance, enabling them to prepare for their first shift. In all the interviews, academics agreed that it was also important for them to be present at the orientation:

I just went because I thought it was good PR and I wanted to know what they said to the students. I was curious myself because I was trying to get my head around things; as a consequence of that, we now recommend that a staff member must attend orientation (Academic 4).

In the interviews, academics acknowledged they were under-prepared for the pragmatics of the Flexible Clinical Education Model, despite their having had a clear view regarding the learning outcomes for the students. Academics were able to reflect on their first experience as Clinical Unit Coordinators for the Flexible Clinical Education Model. They realised that the partnership

between themselves, the Clinical Learning Office and the hospitals was crucial and one that required initiation prior to students commencing placement: this is evident in the reflection, below, of one of the academics:

It established a better, a stronger relationship between the uni and the teachers [preceptors], because you had to work much closer together to actually operationalise this model to, in its most efficient and way (Academic 4).

The orientation was the initial phase of partnership development between academics, preceptors and students. During orientation, preceptors asked students to think about their previous learning experiences and to focus on what their own personal learning objectives were for this placement. By doing this, preceptors encouraged students to reflect on their previous practice to make recommendations for improvement. This provided a perfect opportunity for students to start thinking about what they felt they did well, and that on which they needed to improve. The early establishment of a relationship between academics, students and preceptors cemented the foundations for a strong partnership with a focus on enhancing the student learning experience.

Balance

The strong partnership between university and hospital ensured that balance between clinical placement hours and theoretical learning and work-life balance was achieved for students. For example, preceptors were responsible for organising practical training and with a close partnership they could ask the academics about what theoretical components students had completed, giving them the opportunity to arrange relevant practical experience.

For example, one preceptor commented that once she was aware of content that had not been covered, she could plan a specific teaching session for the students to identify the gap. She commented, 'second year nursing students arrived last year and they had not completed neuro obs [neurological observations]' (Preceptor 3). Once the preceptor realised this, she was able to

run a teaching session for the students who were being placed on the neurological ward. Academics could inform students about the timing of class and clinical experience, which ensured students could attend clinical without hampering their other commitments.

Students commented they felt the Flexible Clinical Education Model allowed them to learn about theory and then apply this new knowledge in the clinical environment. One student commented that they had been learning about tracheostomy care in the nursing skills laboratory on the Monday, and then on Wednesday they cared for a patient who had recently had a tracheostomy. Not only was this beneficial to the student in the clinical setting, the student went on to elaborate that they were able to take this experience back to the classroom and share their experience with the other students, providing practical reality to the topic.

The constant movement between classroom and clinical was evidence that a partnership had developed between university and hospital: student learning was central and valued in both places. Rapport between preceptor and student was integral to student learning. It allowed relationships to develop, setting the student up for an optimal learning experience. In the participant observation it was noted many times that when students felt comfortable with the preceptor they appeared more relaxed and confident. In one participant observation session (PO 4) the researcher noted;

Claire* (preceptor) was just standing at the the end of the bed while Michelle* (student) effortlessly commenced the IV antibiotics. Claire*, was chatting to the patient and there was no sign of distress or worry with Michelle*

The orientation program provided students with the opportunity to identify any gaps in their knowledge; it gave them a safe space in which to seek clarification of the skills and knowledge required to meet the expectations of their practicum. The partnership between university, preceptor and students is enhanced with the Flexible Clinical Education Model when there is a strong rapport among members. Providing a balanced

learning environment where students have prior experience of theoretical procedures ensures a streamlined transference of practical-skill delivery.

Commitment

The Clinical Learning Office liaised closely with the hospital, setting up a date for the orientation day to commence. This date had to fit in with the academic calendar and suit the needs of the hospital. Academics had little input into this date; the academic calendar is the main driver from the university's perspective. Orientation needs to be early in the semester (usually week three) so that sufficient time is available for students to be allocated shifts to fulfill their clinical hours. The Clinical Learning Office committed to arranging a suitable time, the hospital committed to providing a venue and staff attendance, academics and students committed to attending the scheduled orientation.

The first commitment students made to the hospital was attending the orientation day. Students were required to arrive 10 minutes early and were to wear their full Victoria University uniform. Nurses, in terms of rigorous professional practice, complied with rules of conduct as accepted and practiced. The instructions and guidelines to be followed during the clinical placement were established in this orientation day. The obligation of confidentiality, an integral aspect of commitment, was imposed on the nursing profession through the nurses' code of conduct. The code of conduct is especially applicable in situations where the nurse (and student nurses) is confronted with cases of violence or abuse.

Students were required to sign an agreement outlining their commitment to the principles of rostering and the Flexible Clinical Education Model. None of the students thought this was unreasonable as they 'had to do it when they were registered' (FG2). Students felt the orientation inducted them into the hospital and felt committed to the clinical experience as nursing students.

During the orientation day, academics and students came together and met each other. A high level of commitment was required for the students to understand the expectations of the Flexible Clinical Learning Model. The students commented that they gained confidence when the academics and preceptors presented their expectations to students thus reinforcing the need for commitment to the Flexible Clinical Education Model during the placement.

Despite their attendance at the orientation and at clinical workshops, some academics still raised concerns over the quality of clinical education students received during placement as part of the Flexible Clinical Education Model:

I worry about the quality of the preceptorship, supervision. I don't think we have as much control over their clinical supervision. At least with the block model you've got a clinical teacher, so you've got some idea – a dedicated teacher to those eight students – so you've got some idea as to the calibre of the teacher (Academic 4).

In the interviews, it was found there was a lack of understanding, on the part of the academics, of the Flexible Clinical Education Model, which compounded a lack of commitment. There was very little evidence to suggest that academics in the current study recognised that working together lead to benefits that they and preceptors would respect. Universities need clinical placements, for, without them and the support of people within the venues, student intakes would invariably decrease. Universities need clinical placements; clinical venues know this and may 'play off' one university against another; there is little room for loyalty and academics are aware of the importance of keeping clinical venues happy:

Oh, we need to keep the good relationships with the venues where we are doing it, if the students are well prepared and that, like, because if it's organised in such a way, or changes, that becomes a negative, we could lose the placement (Academic 1).

Also:

I think the other thing is, we may have to be a little bit careful about the numbers of students as well, which we could, because [while] we see it as being so good, we could end up overloading a hospital, or an area, perhaps even before they are ready for it (Academic 1).

Another academic offered some insight into how the Clinical Learning Office could keep clinical venues satisfied:

We have to make sure that we are really supporting the staff in clinical land because the moment we stop doing that, that's when they will decide that this is not going to work (Academic 2).

Education for preceptors was seen by another academic as being essential and integral for effective student learning:

We need to support the clinical hospitals, I think we have a responsibility in a partnership with the hospital to um, to educate the staff and give them ongoing support (Academic 4).

One academic agreed that education for preceptors was important however was mainly concerned about the future clinical placements for specialty areas:

I think the biggest capacity constraint to moving the clinical, the flexible clinical learning model forward, is going to be getting it into mental health (Academic 3).

Nursing care is autonomous and collaborative. It is provided to people of all ages, families, groups and communities, sick or healthy, in all contexts; it includes health promotion, disease prevention, and the care of the sick, disabled and dying people. Essential nursing functions include the following: the promotion of a safe environment; research; participation in health policy; management of patients and health systems; training. All these functions require partnerships with different organisations and health care related government bodies, as well as within nursing units.

The ability to interact in different social groups and with people of different ages, the ability to make decisions assertively, and an affinity for health sciences are traits that characterise the value of a nurse. Students

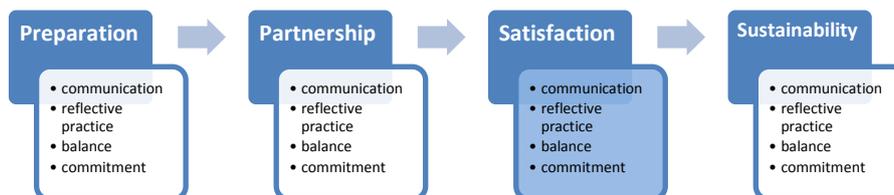
watched academics and preceptors interact, expecting them to work closely together; if this is done successfully they would then model themselves on what they saw. In the focus groups, students commented on how they felt the Flexible Clinical Education Model had a good partnership with the hospital and they believed there was mutual respect between academics and preceptors. Students commented that they felt academics and preceptors were committed to making the Flexible Clinical Education Model work. This was seen in one focus group when a student remarked;

...it was good to see Robin* (academic) talking to all the staff (clinical educators) at orientation, yeah, it was good to know they are taking an interest in us here (FG 3).

The Flexible Clinical Education Model model is based on learning while engaging in practical experience; this has been achieved through the partnership. Many of the students in the focus groups commented that being part of the Flexible Clinical Education Model provided them with a learning experience that helped them feel connected to the hospital. This was reported in a focus group where one student (FG2) confided ‘I feel like I am already a staff member and not just a student’. The sense was that they were more inclined to want to stay as staff once they had graduated.

For the on-going success of the program, the Clinical Learning Office, academics, preceptors and students needed to work together building a partnership based on trust, one where commitment from all members ensured collective benefits.

The following presents the findings under the research question heading; satisfaction.



Satisfaction

This section relates to the research question: How can the Flexible Clinical Education Model provide nursing students with satisfaction of their clinical learning experience.

Communication

Communication is integral to student learning; if students did not receive appropriate communication from academics and preceptors they would struggle to perform competently in the clinical environment. They need to be open about their doubts and communicate all their queries. The focus group interviews revealed that some of the students had not felt comfortable seeking help or guidance from the clinical ward staff:

Because I had a buddy (preceptor) who I wasn't particularly comfortable with with on the ward, made it hard to ask questions. (FG 2)

It depends on the staff though, one um, because they're really abrupt and, um cold. It's sort of, like okay let's not ask questions! (FG 2)

Most of the students, however, felt that the preceptors were there to support and encourage them. This was evident in the participant observation sessions where the researcher witnessed many student learning interactions:

The student actually took the lead and the registered nurse quizzed the student regarding what medications she's had so far. The prompts included things such as, "What's the medication for", and the prompts included things such as, "Yes, you're getting close." "Okay." "That'll do." "Oh, okay, we'll look that up later". (PO 3)

Another comment that the registered nurse frequently made was:

"We don't expect you to know them all at once". They were both laughing, the student nurse and the registered nurse, and they appeared to have a very comfortable relationship. (PO 4)

She then asked, "What do you think is going on?" Then there was quite a detailed discussion about inter-cranial fluid in the brain leading to various changes... So a lot of good discussion that was backwards and forwards. It

was two-way. The student was well involved and was providing some detailed conversation.(PO 8)

From the data, it was apparent that when students received appropriate communication – feedback, informal comments, non-verbals – during preparation, orientation and clinical placement, they felt more connected to the hospital and the learning experience was enhanced.

Throughout the focus groups, there were mixed opinions on whether the Flexible Clinical Education Model assisted students with gaining a valuable learning experience; however, nearly all agreed that they felt more like a part of the team. Feeling part of a team encouraged them to take on more tasks because they felt more supported:

They make you feel like part of the ward. They're like, 'are you coming to lunch', making sure you get your breaks and everything. (FG 3)

I find, like, I walk into here and I do actually feel like a member of staff, whereas in the block one I definitely feel more like a student. (FG 3)

This connection resonated through all the student focus groups and was supported in the preceptor's interviews, with one commenting:

They (staff) see the students in say, August, and then they see them again in December and they are like 'oh, well, you are part of the team'. So they are looking at them as not students, but as part of the team. (Preceptor 1)

The educators and preceptors came together to create an effective learning environment for students. Students commented they needed information from the academics prior to attending orientation and that this was a necessary part of communication that would ensure they were able to complete their practicum in a successful way.

Another issue raised concerned the timing of orientation and their first shift. One student commented, 'I went to orientation in August but didn't have my first shift until mid-October, it was like re-orientating myself' (FG 2). The preceptor explained to the students that a rostering guideline specifically dictated that students were to complete their first shift within two weeks of orientation. Students informed the researcher this was not always

possible, and as long as they made contact with the preceptor they were allowed to commence at a later date. This poor communication about the rostering guidelines frustrated students, resulting in a decrease in their initial satisfaction with the Flexible Clinical Education Model.

From the data it was apparent that when students felt more comfortable with their preceptor, the learning experience was enhanced. This is supported by Levett-Jones, Lathlean, Higgins & McMillan (2009a), whose study looked at the relationship between staff and students and how this affected student learning. The findings from Levett-Jones et al.(2009a, p. 323) demonstrated that ‘positive staff-student relationships are crucial for students to feel accepted, included and valued’ .

When the students in this study felt accepted by the ward and experienced strong levels of communication they felt comfortable taking on new challenges. One student commented ‘Some buddy nurses let you do everything and they support you, are behind you. So it allows you to be independent’ (FG 3). This was supported by another student in the same focus group, who was thinking about her upcoming role as a graduate nurse, ‘I’d say, “I’ll take a full patient load as I’m going to be doing four next year I need to know how”’.

Communication was also an important factor for academics in student learning. The academics must have good communication skills so they can converse with the students and preceptors adequately to ensure knowledge transfer:

There was a lot more communication. So in some ways it was better because it established a better, stronger relationship between the uni and the teachers, because you had to work much closer together to actually operationalise this model to [work] in its most efficient and way....
(Academic 4).

In the interviews, the academics discussed how the Flexible Clinical Education Model could enhance student learning by offering them the opportunity to become immersed in a true clinical environment:

The fact that they have opportunities to work weekends and a night shift is good exposure to the different requirements of the profession. Though some students push it too far, but if it's done properly, I think it's useful for their learning because it's very different working a weekend as far as what resources are available, expertise are available, the sorts of activities that occur (Academic 2).

From the interviews it became clear that academics believed the Flexible Clinical Education Model would ensure students were set up for an optimal effective learning experience.

During the participant observations, it was clear that each preceptor had their own unique ways of imparting knowledge. Some told the students everything they needed to know, others demonstrated the procedure while explaining at the same time. One preceptor constantly asked the students questions to gain an understanding of their knowledge. When the rapport was strong between preceptor and student, it was often apparent that the preceptor was merely observing the student.

As an outcome of the participant observations, the researcher identified four different preceptor teaching methods that either contributed to or decreased levels of communication. The following is a summary of these four teaching methods.

1. Preceptor completes task, student watches, no interaction:

The registered nurse took the lead and the student nurse quietly stood at the end of the bed not talking, just quietly standing. The registered nurse removed the oxygen from the wall and attached it to the portable oxygen cylinder which the orderly had bought up with him. She then moved the IV flasks and the IV Geminis from the mobile pole onto the fixed bed pole.. There was also a catheter bag hanging on the side of the bed and she ensured that this was not going to be caught up in the move. (PO 2)

In this example, the teacher communicates by modelling practice.

2. Preceptor completes task explaining each step to student:

At this point when the student identified that she was unfamiliar with or hadn't seen this procedure, the registered nurse took control and she said 'Okay well what we'll need is, we'll need the conveen, now they come in two sizes and we're not sure which size we'll need so we'll take both to the patient, we need a bag for it to drain into and we need a catheter, a bag holder so that it hangs and not pulls on the conveen'. And she said 'We'll also need a little bit of tape just to put, stick it onto the patient's leg so again it doesn't pull too much'. (PO 8)

As indicated in the heading, this form of communication involves describing and explaining. There is some justification included as well.

3. Student completes the task while preceptor asks questions:

Registered nurse was asking her 'What do you think we will be looking for if you think it is a urinary tract infection, what would you expect to find in the urinalysis?' the student really couldn't answer it very quickly, she said 'ketones' and the registered nurse said 'Oh really, why do you think there would be ketones?' And she says 'Oh I think it's got something to do with metabolism' and the registered nurse said 'Oh what else do you think there might be in there?' and she couldn't think of anything and then the registered nurse said 'Oh what about leukocytes?' and the student went 'Oh yeah okay, yeah'.(PO 7)

In this example, the teacher scaffolds or guides the students' learning, by asking salient questions to elicit and encourage their thinking.

4. Student completes the task while preceptor observes:

Her registered nurse stood by her side the whole time and gave very minimal prompts, it was quite clear that the student was very confident with what she was doing, she knew where the equipment was, was able to go and retrieve the equipment without having to ask where it was, she knew the procedure and the process of placing the antibiotic into the 100ml bag and was quite confident with that. She followed the procedure without a problem. (PO 1)

In this example, there is no explicit communication, rather the student is demonstrating their skills while being conscious that the opportunity to ask a question, seek help or be ready to justify action is apparent because of the presence and attention provided by the preceptor.

All preceptors acknowledged that formal preceptor training would be advantageous and the resultant consistency would improve student learning and their communication with students. The preceptors interacted with the students throughout the clinical placement and one of the challenges was to ensure students understood not only how to perform a procedure but why it needs to be performed. The different teaching strategies often caused distress for some students:

The registered nurse was prompting again, “But there is a formula that we use that specifically provides us with this information” but obviously the student did not know the answer. The student said, “Look, there may be a formula and we may have been taught it but I just can’t remember” (PO 4).

The researcher spoke with this student after this discussion and asked how she felt. She replied she felt ‘stupid’. Students in focus groups also commented on how the different teaching styles of preceptors affected their learning experience:

I’ve come across a few that aren’t suitable to be working with a student, because they don’t get their point across. (FG 1)

I don’t know about anyone else but I just walked in and thought, shit this place is unfriendly. Like I just thought we were getting an absolute grilling. (FG 1)

Positive feedback and developing good rapport was clearly advantageous to students. Myrick & Yonge (2004) reveal that preceptors’ behaviours, such as role modeling and feedback, contributed significantly to students’ learning and critical thinking. This was noted in both the participant observations and student focus group sessions. There were many incidents where good

communication had a positive impact on student learning as the following reflections indicate:

One thing that would be beneficial to students is, um, when your working they [preceptors] say “Oh yes, that’s good, that’s good’ you know, giving constant feedback on how I am going (FG 2).

Some nurses are very supportive and just have that way of teaching that makes you feel proud (FG 3).

During the actual peg feed there was very minimal talking, it was quiet. The registered nurse was happy to stand at the end of the bed and every now and again would give a small prompt. It was obvious that they had developed a trust between each other. There was verbal feedback, such as “That’s it, you’re doing great and well done” and non-verbal where the RN stood at the end of the bed, with her arms relaxed by her side (PO 1).

For all these reasons, the preceptors require good communication methods so that they are able to manage the practical education sessions effectively and foster positive student learning experiences.

Many of the varied duties of nursing students were technical in nature – from taking blood pressure to the management of life support systems in intensive care units. All tasks were always performed under the supervision of a preceptor. In addition, the nursing staff in general were able to teach, counsel and provide administration. The preceptors commented they were concerned with promoting and maintaining the health of patients and teaching students to provide the necessary care.

It was clear from the interviews that preceptors provided students with both dependent and independent experiences. The first were those that had to be carried out under the direction of senior staff, and included activities such as: administration of medication; bandaging and wound management. Independent functions are those that the nursing staff carried out using their own professional opinion and included: attending to hygiene; repositioning patients to prevent joint contractures; patient education to promote wellbeing; nutritional counselling. This was seen as a great learning experience for

students, as they gained practical knowledge. Significantly, the success of the entire system is based on the quality of the preceptor-student partnership.

Reflective practice

From the participant observations and focus group interviews, students commented that they understood the need for reflective practice, and believed that the Flexible Clinical Education Model helped them to do this. On many occasions the researcher witnessed the preceptor showing a student how to perform a task and then shortly after observed the students undertake the same task. Frequently, the students repeated the task in an almost identical manner to that of the preceptor. When asked about this in the focus groups, students commented that they gained more than just physical experience when working closely with preceptors. Often they mimicked their mannerisms and were building their own repertoire of conversation starters to use when caring for patients. This type of learning comes from being encultured to the ward environment, and assumes that learning is fundamentally social (Wenger, et al 2002): it is placing learning in a social context in which the learning is experienced as being meaningful; learning is fundamentally social because we are social beings information by itself is not always enough. This is something that the researcher experienced during her own early learning days:

I worked with a wonderful nurse who was kind and gentle with her explanations of our expected nursing responsibilities of this type of surgery. Barbara* showed me how to clean the split skin graft and explained what to look for when assessing for signs of rejection. She explained colours and described smells all based on her own experiences. I learnt a lot from Barbara. Not just about nursing skills but I picked up on some of her mannerisms that I still use to this day. At the start of every shift she would greet her patients with 'Good morning/ afternoon/ evening', greeting each patient as an equal. In the three months that I worked on that ward I never saw Barbara speak to a patient in a condescending or belittling tone that some of the other staff used. To me, this was a very significant and powerful observation (autoethnography).

Reflecting on good modelling is an essential component of successful learning. Role modelling was not the only learning process that students were exposed to. The Flexible Clinical Education Model provided students with the opportunity to reflect on their own practice and knowledge.

Many of the students commented that they had more time to read up on certain things in between shifts. This meant that when they returned to the ward in two or three days, they had had the opportunity to review their lecture notes on the given topic, and reflect on their experience in the nursing skills laboratories. 'I think it is also like, if you didn't get time to ask about stuff that you don't know on the ward, gives you time to go home and read about it' (FG 1). Students also commented that one of the best things about the Flexible Clinical Education Model was that they had time between shifts to review the literature on unfamiliar issues before returning to the ward. It was this personal reflection on their practice that students commented on as being most useful. It was not always about reflecting on practice, but sometimes students just felt they needed some space to mentally prepare between clinical shifts:

So when I come back, I come back with more energy and like, more prepared to learn more and with some more effort (FG 1).

I'm working on the surgical ward and it's very busy so I am glad to have the flexible cos if it was in a block it would have been too much pressure for me at the moment (FG 1).

Some students even returned to the university laboratories to practise a skill, refining their approach and gaining skills in a technique before they returned to the ward. All students agreed that this time gap between shifts offered ample time for them to reflect and learn before their next shift.

In the Flexible Clinical Education Model model, reflection helped students obtain clarification of their own performance. One of the roles of the preceptors was to examine students and their practices to better understand and be aware of their learning needs. One of the resources used to provide feedback to students was through documentation on the preceptors daily

feedback form (Appendix 8). This form was completed by each preceptor at the end of each shift. Students were provided with feedback relating to their overall performance on that shift; specific learning objectives could be set that needed to be undertaken prior to the next shift.

Another way of providing students with the opportunity to reflect on their learning needs and experiences was through a debriefing session usually conducted by preceptors on the completion of every shift. Often during a block model students on a morning shift would leave the ward at 1pm for lunch and go directly from their lunch break to a debriefing session. On conclusion of the debrief they were dismissed and did not return to the wards. This resulted in students only gaining six hours on ward time (7am-1pm) compared with the full eight hours (7am-3pm) for which they were scheduled. The Flexible Clinical Education Model, however, was designed not to include a formal debriefing session, ensuring the students experienced a full shift:

I think that's been a good thing about it, not only from the student perspective but from the multidisciplinary team. They see them there for the whole shift and think "Oh they are part of the team" (Preceptor 1).

One preceptor was vehemently opposed to the debriefing occurring during shift time and resented students leaving the ward early. This is evidenced by:

Yeah, because that would annoy you, as a nurse, having a student say "I'm leaving at 1pm because I've got debriefing, so I'll go to lunch at 12:30" and I'm like "Well don't bother turning up" (Preceptor 4).

From the focus groups, the students often commented that the debriefing session was not useful and it was often not designed around their individual learning needs. This then denied them valuable clinical learning time that involved receiving structured feedback from the preceptors as to how they could individually improve their practices:

I think the eight and half hour shifts are better because you can program yourself to have sort of a better time management... whereas on the block

model sometimes when its quiet and there are (staff) like ‘ “You can go home”, well we don’t say no (FG 3).

Another student elaborated on this, suggesting the debriefing time was unproductive, and supported the notion that staying on the ward for the entire shift was beneficial, even though she would have preferred to leave early:

I think in first year that debrief is great, it gives us a bit of time to slack off. But now it’s our final year, I mean we don’t like it but it’s a good chance to learn being responsible (FG 1).

From the interviews and participant observations, it was noted that all participants agreed the extended learning period was extremely beneficial to student learning. Preceptors conceded that the Flexible Clinical Education Model allowed greater opportunity to discuss clinical situations with students on placement:

Because its (Flexible Clinical Education Model) got that three month period, if you identify that they’re (students) a little bit weaker, you can even put into place strategies ‘okay, you need to go back to uni and maybe refresh on these skills’ you know ‘go back and spend some time in the labs before you come back for your next shift’. Whereas in the block model you don’t have this much time and they can’t miss two days (Preceptor 1).

Preceptors appreciated the time between shifts stating that this gave students the time to review uncertainties and to absorb the learning experience.

Balance

Balance was integral to student learning and ultimately satisfaction. If students could balance their theoretical and practical knowledge appropriately then it was possible to achieve a high sense of learning satisfaction. Without exception, all students in the focus groups agreed that the Flexible Clinical Education Model gave them a greater balance between university requirements and paid employment, while at the same time balancing their home and social life. The Flexible Clinical Education Model gave students greater flexibility to

balance all issues that were important to them. By giving them this flexibility, students focused more on their learning rather than focusing on ‘just getting it over’:

I found the flexible [FCEM] more relaxing and less stressful; it’s because I did three days a week and so I had four days off for doing other things. So when I came back, I came back with more energy and prepared to learn more (FG 1).

Another student supported this, and commented that because she was choosing when to come to work, she felt more ‘empowered’ and ‘engaged’ and said her learning ability was greater.

Students commented that the Flexible Clinical Education Model permitted them to balance their financial, family and social lives around university and clinical commitments. It was evident that students required adequate notification of when and where their placements were. More time meant they were able to prepare their financial and family commitments. This was particularly important when considering a block model. The Flexible Clinical Education Model removed some of the stress associated with balancing clinical placement responsibilities.

From the interviews, it was noted that academics were aware that students faced challenges in balancing theoretical and practical experience and required initial and continued support. In some interviews, academics felt students did not seek clarification relating to the Flexible Clinical Education Model’s intricacies. This meant some students commenced the Flexible Clinical Education Model with a skewed vision of how the model worked. ‘The students think “flexible”, they kind of thought, well OK, I can chose my shifts, I can have what I like’ (Academic 3).

It was evident good rapport was required between preceptors and students. From the participant observations, it was evident that each preceptor had their own teaching style, but all had student learning at the forefront. Preceptors were keen to provide students with narratives on how they balanced shift work with family and social life. This was reinforced in

the preceptor interviews: I know when I was a student that I found it difficult to balance study, work and clinical. Having good time management helped this' (Preceptor 4).

Commitment

Nurses responsibilities are diverse and have a multidisciplinary character. Commitment to the profession was seen as important for learning the different aspects of nursing provided in the Flexible Clinical Education Model model. It was clear from the focus groups that when students felt committed to the Flexible Clinical Education Model and the hospital, their learning was heightened. One student commented that they had completed three rotations in the Flexible Clinical Education Model, and thought it was 'the only way to do clinical', as she really felt like part of the ward. This commitment ensured students came to work ready to learn and were not just there to 'complete their time'. It is this total immersive experience that brings together all the elements of the nursing profession in a safe and supportive way.

It is impossible for academics to provide all the potential theory students may require prior to each clinical placement; the lecture topics are set to meet the learning objectives for the corresponding clinical unit. Academics aired their frustration when students did not turn up for lectures. One academic noted that she had arranged for a highly regarded expert in cancer treatments to give a guest lecture to students; however, only 32 out of 275 students attended the lecture. The academic said she was 'embarrassed' at the poor turnout and 'disappointed' that the students had missed out on a valuable learning opportunity.

Students also need to be committed towards their study while they are part of Flexible Clinical Education Model; this will prepare them as a registered nurse. As lectures are not compulsory, many students opted not to attend. Instead, they intended to review the lecture content online at a later date. Sometimes this did not occur and students missed vital information: 'I probably didn't even read that lecture you know, and that stuff comes up on

your first shift, and how ironic is that, yeah' (FG 2). Students were encouraged to act as professionals and were expected to have the same level of commitment to their learning as professional nurses. The gaps between shifts provided students with the opportunity to review missed lecture content

Students were provided with theoretical education on the roles and functions of a registered nurse. In the clinical environment, students had opportunity to witness how a registered nurse interacted with other nurses, health care professionals and patients. Students learned by observing the level of the preceptor's commitment. They learned the importance of commitment not only of the registered nurses, but also to their profession. One student commented that being part of the team made her work harder and at the end of the shift her preceptor had said 'thanks for all your help today'. This commitment to the ward and appreciation gave the student a great sense of satisfaction:

Knowing you've walked out and you've actually done a good job, you know, someone's, been happy with what you've done, that's a good feeling (FG 3).

From the interviews, academics acknowledged they required the Clinical Learning Office to provide them with clear instructions. Being committed to providing students with adequate information, academics sought clarification and guidance from the Clinical Learning Office and indicated a willingness to follow the instructions:

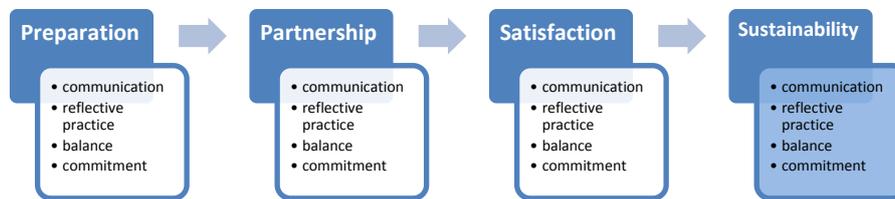
It just kind of meant that I had to get myself into the information loop that was happening through the clinical learning office. And once I was up to speed with that, I thought that was OK (Academic 3).

From all the interviews and focus groups, it was apparent that information from the Clinical Learning Office was provided well before orientation. Students requested a briefing session about the Flexible Clinical Education Model, and academics and preceptors supported this notion. If this information were provided well before orientation, it would assist in the

orientation process. Students felt they were more committed to their first shift when information had been provided to them.

The data showed that all participants needed commitment to the Flexible Clinical Education Model. This commenced with ensuring appropriate information was available to all members. Once a participant was aware of their role and requirements, then commitment to learning and the requirements of the model ensued.

The following presents the findings from the final research question heading; sustainability.



Sustainability

This section relates to the final research question: How can the Flexible Clinical Education Model be sustainable within the Bachelor of Nursing?

Resources were identified as a significant concern, particularly with academics. The main focus was on the pragmatics of the Flexible Clinical Education Model rather than specifically on student learning. The Clinical Learning Office implemented the practical placements and the members were required to reflect on the different teaching and learning practices in order that they constantly evolve and improve the system. The main role of Clinical Learning Office was to organise and plan the different aspects and patterns of clinical teaching. Reflecting upon past or present practices helped identify flaws in the system and led to the creation of a different educational model.

Reflective practice

Students commented that they needed as much information as possible in a timely manner, to help them prepare adequately for their clinical placement. Students were able to reflect back on their previous clinical experience and gain insight into the knowledge they gained at previous venues; this began their preparation for upcoming placements. To do this, students needed to be aware of where the venue was and what type of ward they were going to be placed on. For example, one student commented that if they knew they were going to be placed on a neurology ward they would review their neurology lectures prior to attending their placement. This is the information that the Clinical Learning Office can provide to students to assist them with preparation for practice, based on their previous learning.

The members of the Clinical Learning Office organised and implemented orientation so that the educators, students and preceptors came together. Past orientations were reflected upon and improvements were incorporated. Academics, preceptors and students all acknowledged the importance of attending orientation.

The Clinical Learning Office was an integral component of the Flexible Clinical Education Model, and provided adequate preparation for students, academics and preceptors. This ensured students were well prepared for their clinical placements, ultimately setting them up for a positive learning experience

Balance

The staff in the Clinical Learning Office provided a platform for the academics and preceptors to implement the Flexible Clinical Education Model. It was apparent from the interviews that academics were inadequately prepared for the Flexible Clinical Education Model:

I felt a little bit out of touch with exactly how it was going to work, you know I had the idea of the flexible model but I wasn't in touch with all the details. (Academic 3)

It was acknowledged, however, that once academics identified a question, the Clinical Learning Office assisted them with their queries.

Nevertheless it wasn't a huge problem; it just kind of meant that I had to get myself into the information loop that was happening through the clinical learning office...once I was up to speed I was ok. (Academic 3)

This was echoed by all academics who acknowledged that their understanding of the Flexible Clinical Education Model was minimal and somewhat basic; they all admitted that once they had identified their deficit the Clinical Learning Office staff answered their queries and directed them to an extensive literature resource available on the local server.

The main function of Clinical Learning Office staff was to supervise the entire process and to make it effective. When student allocation, preparation and orientation were cohesive, then student learning was optimal; to ensure this took place, the staff in Clinical Learning Office made connections with different health care centres, hospitals, educators and preceptors to facilitate teaching.

The Clinical Learning Office planned and initiated different partnerships that formed the basis of the Flexible Clinical Education Model: the relationships between students and teachers were established on platforms created by the office; office was responsible for ensuring legal contracts were established and maintained between the university and each clinical venue; the office organised and implemented orientation, ensuring partnerships between the educators, students and preceptors were initiated; students were offered the opportunity to identify and know the preceptors and to learn the details of clinical placement; at orientation, all participants were provided, electronically, with relevant contact details.

The Clinical Learning Office created partnerships with academics and preceptors to provide students with the best learning options possible; the supportive nature of the professional relationship with hospitals, based on practical experience, aimed to provide the best learning environment.

Commitment

Commitment to the Flexible Clinical Education Model is needed for it to continue in the Bachelor of Nursing program. One of the strongest complaints from students related to the timing of the release of clinical preferences. Students commented that sometimes it was only ‘days’ before the placement started that they were notified of their commencement date; however, this was the worst case scenario. Most students agreed that they generally received between two to four weeks notice; however, they indicated that they needed more notice. In the critical phase of preparation for clinical placement, adequate and timely notification to students, academics and preceptors was required to ensure that all members were available and committed to attend the orientation session. It was noted by the Clinical Learning Office that this was an area in need of significant improvement.

The commitment of the Clinical Learning Office towards providing an effective learning experience that involves expanding nursing knowledge, gaining practical experience, developing a team approach and becoming a member of a learning community of nurses is critical to the success of the Flexible Clinical Education Model. The office is committed to the organisation and planning of every aspect of both the practical and theoretical learning options. When students were provided with adequate preparation and a suitable timeframe, they were best prepared for a clinical environment that promoted a positive learning experience.

Summary

In this chapter the findings from the study have been presented. Four elements; preparation, partnership, satisfaction and sustainability, contributing to enhanced student learning have been used to provide a framework that underpins responses to each of the four research questions. Four themes that emerged from the data; communication, reflective practice, balance,

commitment, have been used to elucidate the impact of the Flexible Clinical Education Model in enhancing student learning.

Under each research question the findings have been discussed further under these four emergent themes. Communication has been considered as a major theme as it resonated strongly throughout all interviews and participant observation sessions.

This chapter has presented findings from the data and has addressed the challenges students may experience when they work as registered nurses. Evidence has been presented that indicates the Flexible Clinical Education Model helped students connect theory to practice better than the conventional 'block' approaches of clinical education. The findings suggest that this new balance of practical and theoretical education ensures that students gain a better understanding of the clinical environment and that it enhances their overall clinical learning experience.

CHAPTER 5

Discussion

Introduction

This chapter revisits learning theories, presented in Chapter 2, and discusses data identified as pertinent to the Flexible Clinical Education Model. The chapter also provides an overview of how the findings of this study support the Flexible Clinical Education Model as representing ‘best practice’. The principles included in Best Practice Clinical Learning Environment (Darcy Associates, 2009) are presented alongside a discussion of how the Flexible Clinical Education Model aligns with these principles. In addition, this chapter draws attention to contributing factors that were seen to enhance student satisfaction and learning in the clinical environment. Finally, this chapter concludes with a discussion of how the Flexible Clinical Education Model meets the needs of each research question. The following is an overview of theories of learning which support the principles embedded in the Flexible Clinical Education Model.

Theories of learning

In Chapter 2, theories of learning were first presented; three broad perspectives tied to behaviourism, cognitive, constructivism models of learning were discussed. Over the past few decades, developments in cognitive learning theories have led to a greater understanding of how students acquire clinical expertise (Spencer, 2003). Foremost among these theories is the assertion that

most students learn more effectively if instruction is systematically organised and coherently sequenced. In particular (see, for example, Lam, Irwin & Chow, 2002; Spencer, 2003; Kauffman, 2003), cognitive and constructivist approaches encompass well-defined objectives and meaningful theoretical frameworks to guide both formal and opportunistic learning. Adding to this, Woolley & Jarvis (2007) suggest that educational opportunities need to be appropriate for a student's stage of intellectual development; furthermore, they maintain that skill acquisition should take place within the context in which it is to be applied. The findings of this study support this notion, with communication and preparation between all members as the crux of good learning.

Several scholars define learning as experiential and individual (see, for example, Rogers, 1951; Kolb, 1993; Merriam, 1993; Hansen, 2000; Billett, 2001;) and further propose learning in the workplace as more than incidental. For Billett (2001, p. 19), 'learning and working are interdependent' where people go about their work interacting with colleagues and supervisors while their behaviour, attitude, knowledge and skills in the workplace are constantly being formed and reformed. This theory of learning, known as 'situated learning theory', proposes that people are actively engaged in making sense of their world—they are not 'empty vessels waiting to be filled with knowledge', but are actively involved in striving to make sense of the world (Billett, 2001, p. 30). Situated learning, therefore, is dependent on the particular context and social relationships, each of which is embedded in a particular context of practice.

The data obtained in this study supports the importance of relationships in facilitating effective and conducive learning environments. Students in the focus group interviews commented that it was important for them to feel valued and that they had a good relationship with the preceptor: this had the effect of motivating them to become more involved in their learning. This is well supported in the literature, which establishes that strong relationships with peers, preceptors and academics leads to enhanced feelings of

belongingness (Levitt-Jones & Lathlean, 2008; Levett-Jones, et al. 2009a; Levett-Jones, et al. 2009b). A constructive and positive relationship between the preceptor and student provides an ideal learning environment for both parties. For the students in this study, there was a sense of being part of the team, and in the focus groups they described feeling more like colleagues than students. For the preceptor, a solid rapport with students enabled a more streamlined and time-efficient approach to patient care

Cognitive psychology research has shown deliberate practice to be an important tool for developing and maintaining professional expertise. This form of psychology, according to Ericsson (2004), is characterised by attention, concentration, effort and repetition of skills, until performance becomes fluent and automatic. Deliberate practice, suggest van Merriënboer & Sweller (2010), is facilitated by deconstructing tasks into their component elements to reduce the cognitive load on students during learning. Students are then able to concentrate on higher-order processes, such as problem solving.

Observation and feedback from preceptors, based on well-defined outcome measures, are essential components of deliberate practice that can assist students to focus on areas of strength and weakness (Conn, Lake, McColl, Bilszta & Woodward-Kron, 2012). In this study, some students sought positive feedback and encouragement and commented that when it was received, motivation and commitment to learning was boosted. Confirming positive feedback is required for motivation and commitment (Gielen, Peeters, Dochy, Onghena & Struyven, 2010). Feedback from preceptors was a topic that students found contentious. Some students preferred preceptors showed them what to do, while others voiced their preference for preceptors who pushed them to think more about the procedure or skill they were performing. Students commented that sometimes they sought independence or minimal supervision, which enhanced their confidence to perform at the beginning practitioner level.

From the data, it was noted that students needed to build their knowledge and skills actively, through an interplay of existing expertise with new experiences. They then scaffolded and constructed new knowledge based on their existing level of expertise. Students also needed opportunities to consolidate their new-found knowledge and skills and engage in different practicum settings to develop a more sophisticated skill and knowledge base in the nursing profession. The students in this study were in their final clinical placement and were actively preparing themselves for their graduate year. Regardless of the type of feedback provided, students commented that feeling they were part of the team, where they were supported and encouraged to undertake tasks, enabled them to focus on becoming competent for their upcoming role as a registered nurse.

In addition, the Flexible Clinical Education Model aimed to provide students with a positive clinical learning environment that maximised the achievement of learning outcomes and capitalised on the expertise of both clinicians and faculty. The following is a discussion of how findings from this study met best practice for learning in the clinical environment and where the principles of the Flexible Clinical Education Model matched, improved or were lacking in this regard. The discussion that follows matches the Flexible Clinical Education Model with Best Practice Clinical Learning Environments: it links the evidence found in this study, the responses to the research questions and the key themes of the Flexible Clinical Education Model; it draws the results together under the headings of preparation, partnerships, satisfaction and sustainability.

Best Practice Clinical Learning Environments

As mentioned in Chapter 2, the Best Practice Clinical Learning Environments framework was established in 2009, as part of a comprehensive strategy developed by the Department of Health. It was aimed at enhancing the capacity and quality of clinical placements in medicine, nursing and allied

health in Victoria (Darcy Associates, 2009). It was envisaged that the Best Practice Clinical Learning Environments framework would be used by universities and other training providers, health services, educators and learners to inform policies, practices and behaviours, improving clinical training experiences for all concerned.

The Best Practice Clinical Learning Environments framework asserts that, to be effective, clinical learning environments must provide learners with an opportunity to experience the reality of professional practice in their chosen profession in a safe and supportive environment. According to the Department of Human Services, clinical settings that are seen to have positive outcomes on both staff and students typically adopt the following six key elements listed below:

1. An organisational culture that values learning
2. Best practice clinical practice
3. A positive learning environment
4. A supportive health service-training provider relationship
5. Effective communication processes
6. Appropriate resources and facilities (Darcy, 2009, pp. 75-78).

The six elements highlighted above are the essential underpinnings for a quality clinical learning environment, with many of the elements overlapping or interrelated; however, if clinical learning environments are to represent best practice, more than the minimum standards are required. The following is a discussion of how the findings from this study demonstrate how the Flexible Clinical Education Model aims to meet the above criteria.

An organisational culture that values learning

In the context of a health service, an organisational culture that values learning ensures education, educators and students are valued (Darcy Associates, 2009). Victoria University first recognised the financial merit of the School of

Nursing and Midwifery Project when early findings achieved the objective of reducing the cost of clinical educators. It was also acknowledged by Victoria University and industry (Hospital X) that the School of Nursing and Midwifery Project showed potential for improving student learning. Both organisations were encouraged by the use of student-focused outcomes and supported the further development of this model with the establishment of the Flexible Clinical Education Model.

It was evident from the interviews and focus groups that the Flexible Clinical Education Model provided an organisational commitment to teaching. In the interviews, preceptors remarked they began to recognise undergraduate students as potential colleagues and commented that they accepted them more willingly on the ward. This was in stark contrast to the traditional supervision model, where staff in the interviews commented that students were a 'hindrance' and 'slowed them down'. In the Flexible Clinical Education Model, students completed a full 8.5 hour shift and preceptors and students attributed the extended ward time presence as a positive move towards acceptance. Preceptors on the wards encouraged students to attend professional development seminars offered to Hospital X employees, further supporting the notion of an organisational culture that values learning.

Both organisations ensured preceptors were appropriately rewarded for their work and their skills as educators were respected. Victoria University supported the Flexible Clinical Education Model by offering a preceptor education program to all clinical staff, and Hospital X established a dedicated teaching position (Clinical Facilitator) to provide an additional education career pathway. The clinical facilitator position was established with input from both university and industry in the formulation of a position description. Academic staff and preceptors voiced their approval of this position as it provided a central point of communication regarding student queries or issues.

Both organisations expected clinical staff to take on undergraduate students, with the arrival of future students anticipated and planned for. The

orientation day played an integral part in welcoming students. The importance of attending this day was emphasised by students, academic staff and clinical educators. Students commented that on arrival to the hospital, they felt they were treated as part of the team, respected for what they brought (new ideas, critical appraisal and future workforce) and were given learning opportunities.

The clinical venue was included in all aspects of the early planning phase in an effort to promote positive commitment to the Flexible Clinical Education Model from all staff. The findings from this study support the principle that the Flexible Clinical Education Model promote a positive learning culture between key stakeholders. Discussions between academic staff and the clinical facilitator occurred and resulted in the establishment of a dedicated educational area for nursing students. Students acknowledged appreciation of this space and commented in previous clinical placements that it was often difficult to find a room where they could undertake private study. Students noted this designated area provided opportunities to review lecture notes relating to patients they were caring for, as well as offering a community hub where students could meet.

Communication between Victoria University and Hospital X ensured academic staff, preceptors, students and the clinical facilitator felt supported and valued however, the findings did not support that communication was always explicit or provided: gaps in the delivery and receiving of information did occur: this was evident between students and academics where academics believed students had been provided with the information (via electronic platform) and students commenting they had not received information pertinent to their placement. Nonetheless, the data findings established that the Flexible Clinical Education Model provided an organisational culture that valued learning, underpinning the concept of best clinical practice.

Best clinical practice

Best clinical practice not only is a ‘reflection of the skill, knowledge and competency of staff, but also of the adoption of best evidence into practice, which is both an individual and an organisational responsibility’ (Darcy Associates, 2009, p. 75). Recruitment of highly skilled staff was a key factor in the implementation of the Flexible Clinical Education Model. As mentioned previously in Chapter 3 a dedicated clinical facilitator was appointed by Hospital X in consultation with the clinical coordinator at Victoria University. This role was pivotal to the establishment of an organisational culture that promoted skill development among its clinical staff. The position description indicated that the clinical facilitator was responsible for ensuring guidelines were provided for all activities undertaken, including clinical services, administration and education. Policies and procedures were the basis for delivering consistent standards of service across the organisation and provided an important resource to assist in the enculturation of learners. As such, Victoria University provided Hospital X with student clinical procedures, which also included learning objectives for each clinical placement.

In addition to having highly qualified staff, the data findings highlighted the need to ensure that regular reviews of preceptor clinical practice were conducted to maintain high standards. The clinical facilitator was the linchpin between the university’s clinical learning office and the clinical staff at Hospital X. In the individual interviews with clinical staff, and in student led focus groups, it was stated that the clinical facilitator was well respected by all parties because of the ability to liaise effectively among all staff.

The position description outlined that the clinical facilitator was to ensure both Hospital X and Victoria University policies and procedures were accessible to learners, and that they were written in language that was clear and non-technical, using limited jargon. The documents were easily identified in a white folder with the blue Victoria University logo. They were located in each ward. The documents were ‘user friendly’ and could be easily understood by someone unfamiliar with the document. One such document,

particularly relevant for keeping contemporaneous records on student learning, was the preceptor's daily notes (see Appendix 9). This document was developed by the clinical facilitator for the Flexible Clinical Education Model to provide preceptors with a template that provided daily feedback on individual students. This document ensured contemporary notes regarding student performance were captured. A positive outcome of such note-taking was that detailed accounts of student progress were accessible to the clinical facilitator, enabling accurate formative assessments and summative evaluations to be recorded for each student. The recruitment of expert staff and the introduction of innovative documentation confirmed the data findings that the Flexible Clinical Education Model meets best practice in clinical practice.

A positive learning environment

The positive learning environment concept is complex to define, in part because it is a subjective concept; i.e., the elements that might make a learning environment positive from a clinical educator's perspective might not be the same elements that make it positive from a student's perspective (Darcy Associates, 2009). The following comments summarise data findings gathered from students and educators regarding the aspects of their experience of the Flexible Clinical Education Model that promoted a positive learning environment.

Students in the Flexible Clinical Education Model frequently commented (see Chapter 4) that a welcoming environment was achieved where students received an appropriate orientation/induction. Students commented they were made to feel wanted and valued (and were not a burden or hindrance) when staff took the time to remember their names. The student participants in this study also asserted that involvement in staff activities such as professional development helped them to feel part of the nursing team. This finding is consistent with the findings of Levett-Jones et al. (2009, p. 12) who claim that 'students viewed active participation as essential to their learning and

professional development'. Other significant factors that created a welcoming environment, as noted by the student participants, included being invited to join staff during lunch breaks, being provided with a staff car parking permit and having access to the code for patient results. In summary, because of these inclusive actions, many students noted they felt a stronger sense of belonging. This feeling led to greater levels of student satisfaction with the Flexible Clinical Education Model model.

It was also seen as vital that the clinical educators had knowledge of the expected educational outcomes of the program. In addition to this, it was important that educators had knowledge of learners' proficiency levels and were aware of effective teaching and learning strategies that fuelled an optimal learning environment (Darcy Associates, 2009). At the commencement of the Flexible Clinical Education Model, the clinical facilitator and preceptors were provided with the clinical unit study guide and the corresponding theoretical unit guide. From the content in the unit guide, the clinical facilitator was able to note that students who would be attending the neurological ward would not have the skills to insert and care for a nasogastric tube prior to this placement. Once the clinical facilitator informed Victoria University of this deficit, students unfamiliar with this nursing procedure were provided with a structured educational program that was delivered by the current clinical coordinator in the university's skills laboratories. There was an expectation that these students would complete this program before commencing their first shift. Preceptors were then able to support participants with further professional development on the ward to consolidate their learning. Students in the focus groups corroborated that feeling included in ward activities provided a positive learning environment.

It was evident in this study that a community of practice was in place; this is described by Wenger (2006, no page given) as 'groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly'. A community of practice theory underpins the principles of the Flexible Clinical Education Model, ensuring student

learning is central: all members learn from each other, and have an opportunity to develop themselves personally and professionally. In the Flexible Clinical Education Model, all of the multidisciplinary team (including health and allied staff) are engaged in teaching the students, thus enhancing the students capacity to learn. Social theories of learning suggest that learning occurs in the 'lived experience of participation in the world' (Ranse & Grealish, 2006, p. 172). Students are social beings and place importance on acceptance through inclusion in the group. It is because of this that the communities of practice theory has been proposed as a good fit with evidence emerging from local and international studies of nurses as learners (Edgecombe et al., 1999; Ranse & Grealish, 2006; Levett-Jones et al., 2009).

The Flexible Clinical Education Model was developed using the principles of communities of practice that promoted clinical staff to become involved as educators with a central belief that the clinical nurses' educational role is vital to the development of students' professional skills and knowledge. This is supported by Moscato et al. (2007) and Darcy Associates (2009), who state that for best practice to occur, there needs to be a focus on quality preceptors who display appropriate interpersonal attributes and are suitably educated for the task.

As far as practical, preceptors were registered nurses with a minimum of one year's experience. To satisfactorily fulfil the requirements of this role, there was the expectation that registered nurses would be reflective on their nursing practice, flexible with their teaching and committed to the education requirements of their profession. This was the minimum criteria identified by academic staff at Victoria University and by the clinical facilitator at Hospital X, when selecting clinical staff as preceptors. From the findings of the current study, students were able to detect easily whether or not preceptors had the desired attributes; negative perceptions were evident in comments noted in one focus group session, where students asserted that not all preceptors were committed to the minimum criteria. Conversely, students in the same focus group commented it was evident in their ward, where all staff

had undergone preceptor education, students felt more supported. Student comments included ‘our ward is really good; all the staff really take an interest in us’ (Focus group 3), and ‘Yeah, the preceptors were really happy to help me, you know, show me stuff’ (Focus group 3). It was evident that preceptors on this ward in particular had a strong focus on student learning. Staff in this ward also expressed the importance of providing students with a positive learning experience, where students felt valued and accepted as part of the nursing team.

In the individual interviews, preceptors commented that they identified their students as ‘potential’ colleagues and wanted to promote the positive aspects of working at Hospital X. One preceptor even admitted to openly encouraging some students to apply to her ward at Hospital X when they graduate. This supports the early work of Reilly & Ormann (1992), who found that preceptors who demonstrated a sensitive and caring nature were more likely to be committed to helping the student achieve their desired learning and practicum-based outcomes; they also stated that if a student was fearful in the learning situation, the student became limited in their ability to think critically and to communicate well with the preceptor. Further, Yonge, Myrick, Ferguson and Lughana (2002) discussed the preceptor’s ability to value, work with, and support the student. This was seen as essential for providing a climate that was conducive to critical thinking and one that promoted the student’s inquiry skills – an observation that is not just isolated to nursing.

Schupbach (2012) claims evidence of the critical aspects of clinical training in audiology includes ideal preceptor qualities and preparation. Not only does preceptor preparation provide a positive learning environment, but it also informs preceptors of the benefits of working inter-professionally and being a good role model for learners. Earlier studies reveal that preceptor behaviours, such as role modelling and feedback, contribute significantly to enhancing student learning alongside critical thinking skills (Coates & Gormley, 1997; Myrick & Yonge, 2004; Billay & Myrick, 2008). Recent

studies that look at nursing student's satisfaction with supervision in clinical practice (Löfmark, Thorkildsen, Råholm & Natvig, 2012) also support the finding that preceptor teaching styles affects student learning. The data from this study show that where effective preceptor education is provided, student engagement is heightened, leading to positive workplace learning.

According to the data analysed in this study, another aspect relating to the construction of positive learning environments was linked to appropriate learning opportunities that encouraged collaboration and team work. Noteworthy, was the impact of inter-professional learning opportunities on improving staff and student morale. Students reflecting on their daily practice when they worked alongside other health professionals, commented on 'understanding what a physio does' (Focus group 1), and 'it was good to join in the doctors round' (Focus group 2). Students received an understanding of how the interdisciplinary team worked leading to a positive learning outcome. A recent study by Lait, Suter, Arthur & Deutschland (2011) demonstrates inter-professional mentoring. This study shows an improvement in patient-centered care where provider commitment was seen as important and students were encouraged to work together with other healthcare professionals in various learning activities.

For a positive learning environment to be achieved, however, it is not just the preceptors who are required to be well prepared. Students need to be prepared to demonstrate professionalism and be willing and able to adapt their learning to new environments. This was apparent in the data from this study, where students often commented they were required to 'adjust' to individual preceptor teaching styles. For example, there was dissatisfaction expressed in one focus group session when a student noted she was dissatisfied when one preceptor told her to gather all the equipment she needed to perform a procedure, but neglected to ask if she had ever performed this procedure previously. For students to be well prepared for practice that ensures a positive learning outcome, Darcy Associates (2009, p. 76) concurs that well prepared learners are those 'who undertake prior

reading and make an effort to find out about their new clinical environment' . Familiarity with an environment, or a particular preceptor, allows students to focus on acquiring new skills and knowledge (McKenna, Wray & McCall, 2008).

Finally, in relation to providing a positive learning environment, Darcy Associates (2009) suggests there should be a continuity of learning experiences that assist students to socialise positively and productively in their professional setting. Positive socialisation processes enable students to develop a deeper sense of belonging and professional identity.

The important role that the orientation day played in assisting a professional socialisation process was a strong theme emerging from this study. Academics, students and preceptors all voiced their approval that during orientation, expectations of the students and staff around professional behaviour were clarified from the outset, creating a positive relationship between preceptors and academics. This assured the students that they were working as a team to enhance their learning experience. Students involved in the focus groups also commented they thought it was good to see academics attending the orientation sessions, as this built familiarity and trust; students were also able to know the academic staff better.

Staff commented that they thought it was good for the students to see that they (clinical staff & academics) communicated frequently about student learning issues. Orientation provided a forum for academics and preceptors to communicate, resulting in a closer working relationship, as they were able to share their expectations for student learning outcomes. Attending orientation sessions assisted both academics and preceptors to synchronise theoretical learning with the practical learning outcomes offered during the clinical placements. Ultimately, the communication between academics and preceptors during the orientation session helped facilitate a feeling of assurance for students that they were well-prepared when going to the clinical placements. In turn, this promoted a positive learning environment

for students, preceptors and academics at the beginning of their engagement with the Flexible Clinical Education Model.

A supportive health service-training provider relationship

Working together, the Flexible Clinical Education Model has fostered a close, collaborative, committed relationship with clinical partners. Edgecombe et al. (1999) claim that for a strong partnership to exist between a university and hospital, cooperation and trust is required to frame an effective and positive learning climate. Maintaining a sustainable and productive partnership was one of the major challenges of the university. Holing & Halberd's (2000) study of nurses' experiences as preceptors revealed several main ideas, with trust central to a positive working environment; their findings note that preceptors needed to value the student's responsibility. Once trust was established, they were able to extend the student's responsibilities (Holing & Halberd, 2000, p. 538). It was seen in this study that effective communication nurtures trust, which is a key component in enhancing relationships. Students in in this study's focus groups noticed this and commented that once preceptors 'got to know them' they were able to take on more of a nurse's role and less of the student role. Rapport building is therefore an essential element for reciprocal development of preceptors, as well as stimulating student learning and the development of the profession.

A supportive relationship developed between Victoria University and Hospital X, with both preceptors and academics noting the recognition, importance and value of each other. One element of this relationship was an understanding by all stakeholders of the institutional and systemic drivers, and the limitations, that affected the design and delivery of clinical education activities. Timing of the Flexible Clinical Education Model was negotiated between both partners, with Hospital X knowing the semester dates and agreeing to an orientation day commencing during week two of each semester. This supportive relationship was fostered through open communication between the partners and strengthened through joint

committees and regular meetings between educators and coordinators. In the first instance, an identified point of contact within each organisation was established: The clinical facilitator role became the linchpin that connected Victoria University and Hospital X; as a result, communities of practice between academics, preceptors and students emerged.

The data have shown that the Flexible Clinical Education Model has potential to allow clinical practitioners and academics to collaborate on challenging and changing current practice. As an approach to community engagement, this way of working has the potential to create a vibrant work and learning environment for both staff and students. The findings from this study demonstrated that a supportive health service-training provider relationship existed between Victoria University and Hospital X through the Flexible Clinical Education Model. The establishment of a communities of practice emerged and facilitated the integration of scholarship and professional practice. There is evidence that a student learning environment enhanced by the Flexible Clinical Education Model collaboration with university-based academics and researchers must occur; effective communication must also exist.

Effective communication processes

Effective communication processes foster interaction and exchange of ideas, and provide clarity about when to communicate, with whom to communicate and how best to achieve the communication (Darcy Associates, 2009). Effective communication processes include mechanisms for easy identification of learners and educators. Edgecombe et al (1999) contend that communication determines how information is passed between the students and the preceptors. With this in mind, maintaining communication was one of the major challenges of the academics interviewed in this study. A number of issues were identified regarding how students were notified of expectations and learning outcomes prior to clinical placements commencing. Students commented that they felt ill prepared by academics, although it was acknowledged that

information was available to students on the electronic network. Academics commented that they felt frustrated when students commented ‘we weren’t given information’, as the academics knew the information was available to students. It became clear that, while academics believed students had been provided with adequate preparation for clinical placement, this was not the case. Students commented that they did not routinely access webct to seek information prior to their clinical placement. This highlighted that the pathway of communication was not always open (see Figure 4.3 Communication and student learning). When all members were present, effective communication was noted; this occurred on orientation day when academics, preceptors and students all commented that the communication was purposeful and effective.

Buyss & Bursnall (2007) suggest effective communication nurtures trust and respect, which is a key component in building relationships. For trust and respect to occur, the Flexible Clinical Education Model provided a central communication contact for academics and preceptors. As previously mentioned, the clinical facilitator provided a conduit between the university and the clinical venue, where information regarding student learning could be navigated. Academics and preceptors were responsible for nurturing interaction and exchange of information to other members of the community. As observed by Wenger (2006), communication channels between the university and clinical venue are not reliant on one individual, but are set up so that communication continues between all members.

Darcy Associates (2009) indicates that feedback is an important aspect of communication: it needs to be specific, timely, balanced, constructive and two-way. The students in this study identified the importance of feedback and commented that this was something they looked for in a preceptor. Feedback timing was a key issue for students, with most commenting they preferred to be provided with feedback immediately following an event or procedure. Students commented that feedback was less effective when provided at the end of the shift, or worse on the interim appraisal half-way through their placement. As an outcome of the original trial of the School of

Nursing and Midwifery Project, preceptors commented that it was difficult to remember how individual students performed. Often many weeks had transpired between observing students performing a procedure and completing the interim or final appraisal. Through discussion with the clinical facilitator and academics, 'clinical preceptor daily notes' were developed. While the daily notes arose from the School of Nursing and Midwifery Project, it was implemented during the Flexible Clinical Education Model; all members commented that daily notes made by preceptors on student performances were a valuable anecdotal tool. They ensured timely and specific feedback, provided achievable learning objectives and provided a two-way communication path between student and preceptor. The daily preceptor notes were a positive example of how effective communication could be achieved. Following from effective communication, the final component of providing best practice in the clinical environment related to the provision of appropriate resources and facilities.

Appropriate resources and facilities

The resources and facilities required to enhance or facilitate clinical learning will vary between health professions, health services and levels of learners. Darcy Associates (2009) suggests that the general principle is learners should have access to the facilities and materials needed to optimise their clinical learning experience. Lack of space and resources are often considered issues in clinical practice, as rooms are limited or require booking by a permanent staff member (Dolmans, Wolfhagen, Heineman & Scherpbier, 2008); access to computers is also limited (Moule, Ward & Lockyer, 2011). These limitations were addressed in the Flexible Clinical Education Model by integrating students with the professional nursing team on the orientation day; at that time, students were provided with a car park pass and relevant key codes to access staff toilets and patient pathology results. Students acknowledged having access to these resources was appreciated, as it made them feel part of the team and also minimised time wasting when trying to

locate a permanent staff member to do things for them. The opportunity to access resources is supported by Levett-Jones (2005), who states reflective learning practice instils a culture of considering actions and experiences to sustain a continuous learning experience.

The nature of the Flexible Clinical Education Model ensured students had adequate time between shifts to access further information required to assist their learning. Time away from clinical practice provided students with an opportunity to access appropriate resources to enhance their learning experience. Students were encouraged to book into the nursing skills laboratories at Victoria University to practice a skill, or to spend time in the library to review a medical condition or unfamiliar medication. Students in the focus groups stated that they were grateful for the time between shifts: they were able to familiarise themselves with unfamiliar skills or terminology at those times. The notion of students having access to appropriate resources, in addition to time between shifts to access information, provided an ideal learning environment. This encouraged good learning practices (such as reflection) that students could maintain throughout the remainder of their education and into practice as a registered nurse.

The final section of this chapter discusses the evidence in this study that supports the Flexible Clinical Education Model being underpinned by a communities of practice theory. This chapter then concludes with a chapter summary.

Preparation

The transfer of nurse education into the tertiary sector has been made difficult because of the need to overcome long held views relating to cherished clinical education practices that are now being challenged. To address some of the contemporary challenges for clinical staff (such as students from multiple universities and increased student numbers), this study looked at how an innovative model of clinical practice could enhance student learning.

A review of the current literature indicates there is a challenge on how to best prepare students for not only the procedural application of skills, but also the social, political and cultural arena of clinical practice (Newton, Billett & Ockerby, 2009). The findings from this study reinforce the value of the social aspect in knowledge translation and learning. The Flexible Clinical Education Model can support a social as well as a cognitive learning theory that informs clinicians of students' potential abilities and provides scope to accommodate the increasingly difficult and critical learning requirements of tertiary-based nursing students.

The data in this study identified that communication was vital to the adequate preparation for all members: students, academics, preceptors and administrative staff within the Clinical Learning Office. There were many gaps, identified in the focus groups and individual interviews, in the communication between members: information moved only in one direction; in some instances it was considered by students and academics as inadequate. For the preparation to be acceptable, two-way communication between all participants needed to be available; Figure 5.1 the interrelationships involved.

Effective preparation provides the fundamental premise where open and frequent communication, in a variety of forums, allows for a partnership to evolve and develop.

Partnerships

Partnerships require common values and interests, engagement in common goals, communication, respect and mutual trust (Harvath, Flaherty-Robb, White, Talerico & Hayden, 2007). Recognition of the importance of excellent innovative partnerships is occurring; however, the challenges are many (Kirschling & Ives Erickson, 2010). In order for tertiary-based students to have access to practice, new partnerships between higher education institutions and

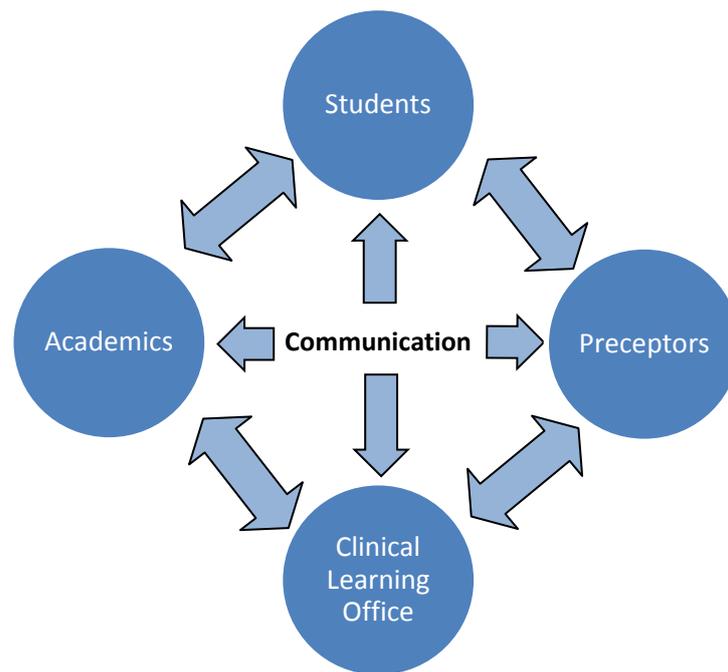


FIGURE 5.1 PROMOTING EFFECTIVE COMMUNICATION

health services are required. Historically, establishing these relationships has been difficult (Bell, 1983); however, maintaining relationships continues to be recognised as essential (Levett-Jones, Parsons, Fahy & Mitchell, 2006). Although it is agreed that clinical nursing education is a shared responsibility between the tertiary and health sectors, there are sometimes misunderstandings regarding the responsibilities of various staff involved in clinical education (Levett-Jones et al., 2006). This was evident from the study data, where communication between academics and preceptors was not always adequate. An example of this was noted when one preceptor commented that ‘she had no idea what the students were able to do’.

For enhanced student learning to occur, all members, according to MacIntyre, Murray, Teel & Karshmer (2009) must be familiar with the learning requirements, including student objectives as well as relationships among where practice is central to students’ socialisation.

Innovative academic-industry partnerships are realigning scarce resources, in an attempt to improve the quality of clinical education and build cultures of safety. An information sheet published by the Department of Health (2012, p. 1) considers partnerships to be critical, stating ‘effective partnerships are essential to ensure that the interests and needs of all stakeholder groups are reflected in strategic planning and initiatives’.

Partnerships between health care facilities and tertiary institutions can provide direct learning opportunities for staff and students. The contribution and effectiveness of learning, regardless of whether it is staff or students, is dependant on robust partnerships between education providers and health services. Effective partnerships and collaborations are dependant on good communication and collaboration between parties. Each party also needs to be able to contribute to meeting the needs of the other party. Clear delineation of roles and responsibilities is essential to ensure good working relationships between partnerships (Henderson et al. 2006).

With effective preparation and clear communication between all members, strong, stable partnerships can be developed. This may assist in establishing a sense of satisfaction among members.

Satisfaction

In a literature review on the topic of supernumerary status of pre-registration nursing students, Elcock, Curtis & Sharples (2007) found that satisfaction with clinical experiences is dependent upon being accepted by the ward staff. This is achieved through a preceptor or a clinical teacher. In the current study, students were encouraged by preceptors to join in with staff conversations and professional development learning experiences. As previously mentioned, students in focus groups commented that they felt more like ‘part of the team’ when staff asked them to join in meals or to participate in staff professional development activities.

Billett (2002) suggests that opportunities for students to engage in clinical practices are shaped by workplace practices grounded in unique histories and traditions. Thus, it is logical to assume that some of the history and traditions of pre-registration nursing education, grounded in the apprenticeship model of hospital-based programs, continue to exist in contemporary health services; where it does exist, a sense of student satisfaction is evident.

Winter-Collins & McDaniel (2000) claim student satisfaction is determined in relationships where a sense of belonging is present and that a sense of belonging has significant positive relationships with total satisfaction, interaction opportunities, praise, control, co-workers and scheduling. The findings from this study support this and more recent studies (see Levett-Jones & Lathlean, 2008; Levett-Jones et al., 2009a, 2009b; Edgecombe, Jennings & Bowden, 2012; Manninen, Welin Henriksson, Scheja & Silen, 2013) that concur that the most important components in students' learning are mutual relationships and encountering a sense of belongingness. This was reported during multiple interviews and in the focus groups of this study, as noted earlier.

Students, academics and preceptors all commented that students' experience of being accepted as a real part of the team was important in promoting student learning. From the data it was shown that the Flexible Clinical Education Model has many facets of historical traditions and is underpinned by the key principles of communities of practice, to be discussed later in this chapter.

Sustainability

For decades, Victorian health services have worked in partnership with education and training providers to offer clinical placements to health students. The demand, however, for clinical placements and the complexity of arranging them have both increased substantially: there has been growth in both the numbers of students and the numbers of institutions offering education and

training in healthcare disciplines (Department of Health, 2011). To ensure that formal partnerships, and that a commitment between education and practice continues, succession planning is vital.

For the Flexible Clinical Education Model to be sustainable, academics need a continuing relationship with preceptors. They also need to participate in ongoing learning activities on the ward, such as preceptor education. In the Flexible Clinical Education Model, students take an active role on the ward in ongoing interactions with staff from many inter-professional disciplines.

Preceptors in the ward take an active role in the education of students. Kirschling & Ives Erickson (2010) claim that active teams, involving many members, allow abilities to emerge from within. In this study, preceptors viewed the time spent with students as an investment in the future of the unit and the profession; one preceptor commented she looks at students as 'potential colleagues'.

Flexible clinical education models and communities of practice

Anthropologists Jean Lave and Etienne Wenger (Lave & Wenger, 1991) coined the term 'communities of practice' while studying apprenticeship as a learning model. Apprenticeships were thought of as a relationship between a student and a teacher. Further studies by Lave & Wenger revealed a more complex set of social relationships through which learning took place. A more recent study by Ransie & Grealish (2007) explored nursing students' experiences of learning in the clinical setting of a Dedicated Education Unit, using communities of practice frameworks; they found formal partnerships and a commitment between education and practice. Wenger's communities of practice model provides a framework for an ideal relationship between students and clinicians. Communities of practice can minimise the marginalisation and alienation experienced by nursing students, and increase their learning through active participation in knowledge generation to improve the quality of care in clinical settings (Berry, 2011).

In the Flexible Clinical Education Model, the social community is a hospital ward where nurses, doctors, families, patients, physiotherapists, social workers, cleaners, receptionists and many others form a practice community. The student enters this community with an identity shaped from experience in previous communities of practice. In joining a new practice community, the student undertakes a unique learning curriculum. Lave & Wenger (1991, p. 97) define a learning curriculum as ‘a field of learning resources in everyday practice viewed from the perspective of learners’. The student, as a newcomer, is exposed to the curriculum, shaped by workplace norms, intended to provide instruction for practice (Lave & Wenger, 1991).

The findings from this study showed the Flexible Clinical Education Model to have a focus on founding principles and adaptation to different clinical contexts rather than a concrete model for clinical learning. The Flexible Clinical Education Model provided a clinical environments in which students developed a sense of security to explore learning opportunities, knowing there were staff present willing to ensure they do not make intractable errors. That is staff who were willing to guide and support them to achieve optimal learning. Being part of the Flexible Clinical Education Model lead students into a complex emersion of nursing work; they identify as nurses and are engaged in the community of practice.

Students in the Flexible Clinical Education Model have the opportunity to use the skills of reflection, peer learning and case comparisons. The Flexible Clinical Education Model fosters energy, where the clinical staff members and students coordinate their work so that their interests align within the broader structures and expectations of the health service agency, the higher education provider and the broader social agendas of government and a range of interest groups.

As described earlier, students in the study came to the clinical placement with their own expectations for the learning experience. Students expressed a willingness and appreciation to engage in the social aspects the Flexible Clinical Education Model offered; these were seen as necessary for learning.

The venue offered opportunities for students to participate in practice for the student to learn. The reciprocal processes of learning and participation are therefore premised on access to tasks of increasing criticality and accountability over time.

Contrary to other models of clinical nursing education (described in the literature review), where students are buddied exclusively with selected role models, this study suggests that nursing students learn when they are engaged in the work of the entire nursing unit. Theoretically, using the premise of social learning, students in the Flexible Clinical Education Model are exposed to a culture of learning by observing and working under the guidance of experienced nurses. In communities of practice, socialisation and building cooperative learning is built around a common practice that leads its members to define certain rituals, roles and interactions determining their language and identity. This leads them to engage, consolidate and develop over time.

Summary

This chapter has provided a discussion of the findings of this study. It commenced with an overview of learning theories that supported the Flexible Clinical Education Model principles. The standards of the Best Practice Clinical Learning Environments were identified and used as a scaffold to discuss findings advocating the Flexible Clinical Education Model to be a best practice model. Finally, this chapter identified how, in this study, the Flexible Clinical Education Model enhanced student learning by meeting the principles of best practice using communities of practice framework.

CHAPTER 6

Conclusion

This study made a distinct contribution to the discipline of nursing – in particular, the clinical education of undergraduate nursing students. Through a collaborative process involving students, academics and clinical staff, the overarching research question **How can the FCEM enable student learning to be central and valued?** has been investigated. This study used qualitative research methods including participant observations, individual and focus group interviews. A notable strength of the current study was the inclusion of students, academics and clinical staff using multiple methods of data collection.

This study confirmed the perception of the researcher that a flexible model of clinical education has the potential to enhance student learning. On the basis of this study the data findings indicate that a flexible clinical education model may assist students, academics and clinical staff to be well prepared to meet the objectives of student placements. It was established that this model generated a partnership between students, academics and clinical venues, which assisted nursing students with satisfaction of their learning experience. Finally this study offers elements of this model that contribute to its sustainability in the Bachelor of Nursing at Victoria University.

This chapter will now present the overall limitations of this study and the implication for new research and professional practice. This will be followed with a presentation of the recommendations that arose from this investigation with the overall conclusion of this study.

Limitations

The limitations noted in the study were the small sample size, the possible impact of the researcher being the Associate Head of the School of Nursing, Victoria University, only a single semester of clinical practice observed, only students in a current single flexible clinical model were involved, and only one venue was involved. Each of these limitations will be addressed in the following sub-sections.

Small sample size

The opportunity to participate in the study was only available to those students who were enrolled in nursing programs at the time of the study. Therefore, those who had withdrawn in the previous three years had no opportunity to express their views. The extent to which this is significant cannot be ascertained. It should also be noted that, although fairly typical of the student cohorts from which they were drawn, the focus group participants cannot be assumed to represent a larger population outside the study contexts.

To keep the qualitative findings in perspective, it is important to note that the sample was relatively small, with participants totalling 18. This is in keeping with qualitative methods, where the purpose is both to add new insights that stimulate debate and discussion around the issues and to enhance transferability by providing faithful and detailed descriptions of the phenomenon. The recurring nature of the themes depicted in the transcripts enhanced the study's credibility.

Intimidation (researcher as Associate Head of School)

Throughout the focus group interviews, the researcher was aware of the potential influence that she might have had on the views expressed by the participants; this was particularly true of the interviews undertaken with students from the School of Nursing, Victoria University, where she was Associate Head of School. To lessen the risk of bias the researcher ensured that

she did not have a current teaching relationship with any of the participants: during the data collection the researcher was not involved with any teaching of this student cohort; as this was their final semester, she was unlikely to be involved in any further teaching of them. The extent to which the researchers presence as the interviewer influenced these students cannot be determined; yet, the candid nature of the students' accounts and the consistency between the experiences described by students from each of the focus groups provided a measure of reassurance that responses were not influenced by her position.

One semester

Data collection was conducted during one semester; on completion of this semester the students completed their studies at Victoria University. This prohibited any further follow up focus groups with students; however, all focus groups were able to be conducted during semester time, to a point where repetition of themes occurred.

Only students in the current flexible clinical education model

Students who participated in this study were completing their final clinical placement as part of the Flexible Clinical Education Model. Simultaneously, students of the same cohort were completing their final placement at Hospital X in a block model. These students were not interviewed. As this study was not comparative, this did not influence the data.

One venue

Data collection was conducted at Hospital X campus. Although only one venue was used, clinical preceptor staff interviews occurred over the four wards where the Flexible Clinical Education Model was delivered. Two medical wards and two surgical wards were part of this study and provided a cross section of clinical staff that were interviewed, ensuring a rich data yield.

The limitations of this study have been presented and noted that the results were restricted to one university and one clinical venue thereby reducing the external validity of results. The positive side is that internal validity is strong and these local results are currently being used to improve the clinical experience for nursing and midwifery students. The potential for other universities, both local and internationally, to replicate the process are sound.

Implications

New research

This study has produced an original contribution to knowledge by addressing an existing problem in a novel way. Evidence from this study has shown that the Flexible Clinical Education Model is best situated to meet all the aims and needs of Health Workforce Australia, undergraduate nursing students, preceptors and educational and healthcare providers. There was strong supporting evidence that the Flexible Clinical Education Model enabled students to practise skills and procedures in a supportive clinical environment and student comments acknowledge they felt ready to begin practising as registered nurses. While the Flexible Clinical Education Model offered more support to the nursing students through the use of a dedicated Clinical Facilitator, there is need to closely examine how preceptors are best prepared for nursing students undertaking their clinical placements. Another good reason that education and health care providers should consider using the Flexible Clinical Education Model in the clinical learning environment is its capability to increase student capacity.

Gaining an understanding of how a professional partnership creates communities of practice enhances the quality of clinical practice and education. Among the key partnerships for health organisations are those with education providers. Both systems depend on each other; education needs to be relevant to the industry in which the new professional will work.

Conversely, health care depends on the quality of education to accomplish its role effectively.

The Flexible Clinical Education Model

Throughout this thesis the Flexible Clinical Education Model has been presented and described as an innovative model of clinical learning. The Flexible Clinical Education Model arose following anecdotal data from a previous, smaller study known as the School of Nursing and Midwifery Program. The School of Nursing and Midwifery Project was trialled to improve student numbers and decrease associated clinical teacher costs, yet incidental student feedback suggested a flexible model provided a greater learning experience than previously attended clinical block models. The inferred evidence warranted further investigation.

The Flexible Clinical Education Model balances university prescribed student learning outcomes with key industry partner needs for work-ready graduates, while adhering to policy mandated by external professional bodies. A collaborative approach provided an optimal environment for faculty and clinical nursing staff to maximise the benefits of clinical placements for students. The model can be adapted to suit individual organisations by ensuring students are career-ready and community minded. The overarching aim of the model was to create a more supportive clinical learning environment, thereby maximising the opportunities for students to achieve learning outcomes, and at the same time, enhancing closer collaborations between clinical staff and academics. The Flexible Clinical Education Model is realised when a community of practice occurs and students, academic and clinical staff are well prepared.

Figure 6.1 demonstrates how the key elements of a Flexible Clinical Education Model create an ideal model of best practice that leads to enhanced student learning in the clinical environment.

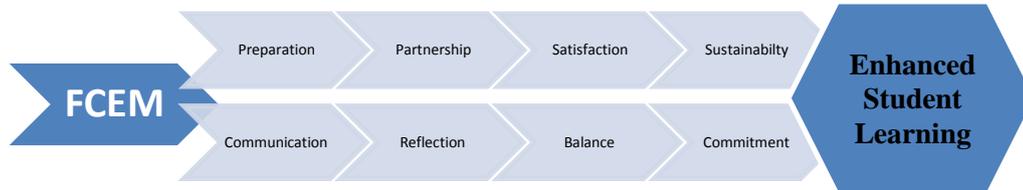


FIGURE 6.1 KEY ELEMENTS OF A FLEXIBLE CLINICAL EDUCATION MODEL

Recommendations

The following recommendations have arisen from the findings of this study:

1. Continuation of the Flexible Clinical Education Model in the Bachelor of Nursing, with an aim to achieve best practice in the clinical learning environment.
2. Improve nurturing and interacting communication pathways between all members. Further research is required in this area to investigate patterns of relationships between all members to ensure improved outcomes for students, academics, clinical ward staff and the Clinical Learning Office staff.
3. Preceptor education to be provided by the university to all clinical ward staff who are working on a ward where the Flexible Clinical Education Model is implemented. Development of strategies for supporting registered nurses (preceptors) working with nursing students that effectively meet the needs of preceptors and university resource needs.

4. Continue to strengthen the professional partnership between industry and education providers. Discussions with key industry partners with respect to the integration of the Flexible Clinical Education Model within the clinical component of the undergraduate bachelor of nursing.

The Flexible Clinical Education Model was trialled in 2010. The model was well received by students, academics and clinical staff and has continued to run since the trial's conclusion. Since its implementation, the Flexible Clinical Education Model now accounts for one third of the total clinical placements in nursing. It is currently running across many of our key industry parties, including Hospital X, and two other major public hospitals in Victoria. A further trial in an acute Mental Health setting has been scheduled for semester one 2014.

Conclusion

Overall, the findings of the current study show that the Flexible Clinical Education Model enhanced the practical learning experience for undergraduate nursing students. The results also indicated that staff, both clinical and academic, valued the Flexible Clinical Education Model as a favourable model of clinical learning. Key features found to be important in facilitating these outcomes included the collaborative nature of the Flexible Clinical Education Model and a sense of ownership by staff and students alike. These factors showed communities of practice were in place that enabled the development of positive learning environments in the wards where students were allocated clinical experience.

Equally important was ensuring that supervision of students in the clinical environment was undertaken by facilitators with preceptorship education and experience. Further, continued support from the university before, during and after each clinical placement was shown to be important,

if not essential. These factors, acting in combination, promoted enhanced access to learning opportunities and improved learning outcomes for students and staff.

Clinical education is a vital component of undergraduate nursing courses. The current study has demonstrated the positive impact of an innovative model of clinical education in the learning experience of students. The study also identified a range of factors that played a pivotal role in achieving quality outcomes for students and nursing staff. The findings propose that positive outcomes are more likely to be achieved when communities of practice exists and is underpinned by a partnership between key stakeholders. The factors that were identified in the current study as influencing the outcomes for students and nursing staff advance the understanding of what constitutes an exemplary model of clinical education for undergraduate nursing students. It is therefore proposed the Flexible Clinical Education Model can promote enhanced learning opportunities for students and findings have unequivocally confirmed that this study has demonstrated an original contribution to practice and knowledge within the nursing profession.

References

- Aitkin, D. & Mitchell, J. (2008). *Diamond Innovations. Thirteen great examples of innovation in teaching and learning at Victoria University*. Victoria University, Footscray Park campus: Melbourne.
- Andersson, C. S., Danielsson, A., Hov R. & Athlin, E. (2013). Expectations and experiences of group supervision: Swedish and Norwegian preceptors' perspectives, *Journal of Nursing Management*, 21(2), 263–272.
- Andrew, N., Tolson, D & Ferguson, D. (2008). Building on Wenger: Communities of practice in nursing. 28(2), 246–252.
- Andrews, M., Wallis, M., 1999. Mentorship in nursing: a literature review. *Journal of Advanced Nursing* 29, 201–207.
- Aston, L., Molassiotis, A., 2003. Supervising and supporting student nurses in clinical placements: the peer support initiative. *Nurse Education Today* 23 (3), 202–210.
- Auerbach, E. R. (1990). *Making meaning, making change: A guide to participatory curriculum development for adult ESL and family literacy*. Boston: University of Massachusetts.
- Australian Nursing and Midwifery Council, (2006) *Registered nurse and midwife education in Australia*. Retrieved 3 December 2002. Available from: http://www.anmc.org.au/docs/guidelines_and_position_statements/Registered%20Nurse%20and%20Midwife%20Education%20in%20Australia.pdf.
- Australian Nursing Federation. (2007). *Review of the impact of the Higher Education Support Act 2003*, from www.anf.org.au.
- Barnett, T., Cross, M., Jacob, E., Shahwan-Aki, L., Welch, A., Calwell, A. & Berry, R. (2008). Building capacity for the clinical placement of nursing students. *Collegian*. 15, pp 55 - 61
- Beal, J. A. (2012) Academic-Service Partnerships in Nursing: An Integrative Review. *Nursing Research and Practice*. March, 501–564.
- Bell, P. (1983). Nursing education in a tertiary setting. *The Australian Nurses Journal*, 12(3), 44–45, 51.
- Benner, P. & Wrubel, J. (1989). *The primacy of caring: stress and coping in health and illness*. Menlo Park, California: Addison-Wesley.
- Berry, L. E. (2011). Creating community: Strengthening education and practice partnerships through communities of practice. *International Journal of Nursing Education Scholarship*, 8(1), pp
- Billay, D. & Myrick, F. (2008). Preceptorship: An integrative review of the literature. *Nurse Education in Practice*, 8(4), 258–266.
- Billett, S. (2002). Toward a workplace pedagogy: Guidance, participation and engagement. *Adult Education Quarterly*, 53(1), 27–43.
- Blatch, G. (2013). *Excellent, Engaged and Accessible: Victoria University College Strategic Plan*. Victoria University.

Appendices

- Borbasi, S., Jackson, D. & Langford, R. W. (2008). *Navigating the Maze of Nursing Research* (2nd ed) Sydney: Elsevier.
- Borneuf, A. & Haigh, C. (2010). The who and where of clinical skills teaching: A review from the UK perspective. *Nurse Education Today*, 30(2), 197-201.
- Bourgeois, B., Drayton, N. & Brown, A.M. (2011). An innovative model of supportive clinical teaching and learning for undergraduate nursing students: The cluster model. *Nurse Education in Practice*, 11(2), 114-118.
- Bostridge, M. (2008). *Florence Nightingale: The woman and the legend*. London: Penguin.
- Brewer, J., D. (2000). *Ethnography*. Philadelphia: Open University Press.
- Briggs, A. (1972). *Report of the committee on nursing*. HMSO: London.
- Brown, A. L. & Campione, J. C. (1995). Designing a community of young students: Theoretical and practical lessons. *Review of Pedagogy*, No. 111.
- Brundage, D. H. (1980). *Adult learning principles and their application to program planning*. Minister of Education Ontario, Queens Park: Toronto.
- Burns, S., Bulman, C. (2000). *Reflective Practice in Nursing: The Growth of the Professional Practitioner*. (2nd Ed.). Oxford, Blackwell Science.
- Buys, N. & Bursnall, S., (2007). Establishing university–community partnerships: processes and benefits. *Journal of Higher Education Policy and Management*, 29(1), 73–86.
- Cant, R., McKenna, L. & Cooper, S. (2013). Assessing preregistration nursing students' clinical competence: A systematic review of objective measures. *International Journal of Nursing Practice*. 19(2), 163–176.
- Chan, D. S. & Ip, W. Y. (2007). Perception of hospital learning environment: a survey of Hong Kong nursing students. *Nurse Education Today*, 27(7), 677–84.
- Chan, D. S. (2004). The relationship between student learning outcomes from their clinical placement and their perceptions of the social climate of the clinical learning environment. *Contemporary Nurse*, 17(1–2): p. 149–58.
- Chan, D. (2003). Validation of the clinical learning environment inventory. *Western Journal of Nursing Research*, 25(5), 519–532.
- Chowdhury, M. S. (2006) Human behaviour in the context of training: An overview of the role of learning theories as applied to training and development. *Journal of Knowledge Management Practice*, 7(2).
- Chuo, J. B., Magerey, J. & Weichula S.R. (2012). Violence in the emergency department: An ethnographic study (part 1). *International Emergency Nursing*. 20(2), 69–75.
- Clancy, A. (2012). The ceremonial order of public health nursing consultations: An ethnographic study. *Journal of Clinical Nursing*, online edition 28 March. Retrieved 4 May 2012.
- Clare, J. C., Brown, D., Edwards, H. & White, J. (2003). Evaluating clinical learning environments: Creating education-practice partnerships and clinical education benchmarks for nursing. Learning Outcomes and Curriculum Development in Major Disciplines: Nursing Phase 2 Final Report. School of Nursing & Midwifery, Adelaide: Flinders University.
- Clare, J. C., White, J., Edwards, H. & Van Loon, A. (2002). *Curriculum, Clinical Education, Transition and Retention in Nursing*. AUTC Phase one Final Report. Adelaide: Flinders University.

Appendices

- Clarke, N., 2002. Job/work environment factors influencing training transfer within a human service agency: some indicative support for Baldwin and Ford's transfer climate conduct. *International Journal of Transfer and Development* 6, 146–162
- Cleary, M., Horsfall, J., De Carlo, P., 2006. Improving student learning in mental health settings: the views of clinical stakeholders. *Nurse Education in Practice* 6, 141–148
- Coates, V. E. & Gormley, E. (1997). Learning the practice of nursing: Views about preceptorship. *Nurse Education Today*, 17(2), 91–98.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 49–71). New York: Oxford University Press.
- Conn, J. C., Lake, F. R., McColl, G. J., Bilszta, J. L. C. & Woodward-Kron, R. (2012) Clinical teaching and learning: from theory and research to application *Medical Journal Australia*, 196(8), 527.
- Council of Deans of Nursing and Midwifery. (2011). *Submission to the Higher Education Base Funding Review*. (Australia & New Zealand).
- Courtney-Pratt H, FitzGerald M, Ford K, Marsden K, Marlow A (2011). Quality clinical placements for undergraduate nursing students: a cross-sectional survey of undergraduates and supervising nurses. *Journal of Advanced Nursing* 68(6): 1380-1390
- Creswell, J. W. (2007). *Educational research* (3rd ed.). Thousand Oaks, CA: Sage.
- Daniels, K. (1998). *Convict women St. Leonards*. St Leonard: Allen & Unwin.
- Darcy Associates (2009) *Best Practice Clinical Learning Environments Within Health Services for Undergraduate and Early- Graduate Learners*. Final Report. Available at <http://www.health.vic.gov.au/placements/resources/index.htm>
- Darcy Associates (2012) *Best Practice Clinical Learning Environments Final Report*. Available at <http://www.health.vic.gov.au/placements/resources/index.htm>
- De Silva, B. S. S. (2009). Health-care system and nursing Sri Lanka: An ethnographic study. *Nursing & Health Sciences*, 12(1), 33–38.
- Department of Health (2011). *Victoria's strategic plan for clinical placements 2012–2015 Well placed. Well prepared*. Victorian Clinical Placements Council.
- Department of Health. (18 June 2012). *Information sheets: Clinical placement networks*. Workforce Strategy and Regulation.
- Department of Human Services (2005) *Prepare Nurses for the Future Report Phase 1*.
- Department of Human Services (2004) *Nurses in Victoria: A Supply and Demand Analysis 2003-04 to 2011-12*. Victorian Government, Department of Human Services, Melbourne.
- Dewey, J. (1938). *Experience and Education Kappa delta Pl Lecture series*. London: Collier-Macmillan Books.
- Discussion Paper (2008), *Review of Australian Higher Education*, Canberra
- Dolmans, D. J., Wolfhagen, I. H., Heineman, E. & Scherpbier, A. J. (2008). Factors adversely affecting student learning in the clinical learning environment: A student perspective. *Education for Health*. 20(3),
- Dossey, B. M. (2000). *Florence Nightingale: Mystic, visionary, healer*. Springhouse, PA: Springhouse.
- Dunn, S. V. & Hansford, B. (1996). Undergraduate nursing students' perceptions of their clinical learning environment. *Journal of Advanced Nursing*, 25(6), 1299–1306.

Appendices

- Edgecombe, K., Wotton, K., Gonda, J. & Mason, P. (1999). Dedicated education units: A new concept for clinical teaching and learning. *Contemporary Nurse*, 8, 166–171.
- Edgecombe, K., Jennings, M. & Bowden, M. (2012). International nursing students and what impacts their clinical learning: Literature review. *Nurse Education Today* 33(2), 138–142.
- Edwards, H., Smith, S., Courtney, M., Finlayson, K. & Chapman, H. (2004). The impact of clinical placement location on nursing students' competence and preparedness for practice. *Nurse Education Today*, 24, (4), 248–255.
- Eggen, P. & Kauchak, D. (2004) *Educational Psychology: Windows on Classrooms*. (6th ed). Pearson Prentice Hall: Upper Saddle River, NJ.
- Elcock, K. S., Curtis, P., & Sharples, K. (2007). Supernumerary status—An unrealized ideal. *Nurse Education in Practice*, 7, 4–10.
- Elliot, M., 2002. Clinical education: a challenging component of undergraduate nursing education. *Contemporary Nurse* 12 (1), 69–77
- Engeström, Y. (2004). New forms of Learning in Co-Configuration Work. *Journal of Workplace Learning*. 16: 11 - 21
- Estabrooks, C. A., Thompson, D., Lovely, J., & Hofmeyer, A. (2006). A guide to knowledge translation. *The Journal of Continuing Education in the Health Professions*, 26(1), 25–36.
- Franklin, N. (2013). Clinical supervision in undergraduate nursing students: A review of the literature. *Journal of Business Education & Scholarship of Teaching*, 7(1), 34–42.
- Frost, A. (2014). *A Synthesis of Knowledge Management Failure Factors*
January 25, 2014 retrieved 21/05/2014 www.knowledge-management-tools.net
- Fry, M. (2011). An ethnography: Understanding emergency nursing practice belief systems. *International Emergency Nursing*. Online October 2011. Retrieved 4 May 2012.
- Fuller, A., Hodkinson, H., Hodkinson, P. & Unwin, L. (2005). Learning as Peripheral Participation in Communities of Practice: A reassessment of Key Concepts in Workplace Learning. *British Educational Research Journal*. 31 (1): 49 - 68
- Gardner, L., Rolfe, G., & Ghroum, P. (2013). The Theorist-Practitioner Gap: Bringing The Two Sides Closer Together. *Mental Health Practice*, 16(6), 12-16.
- Garrido, A. (2003). Learning as an identity of participation in the processes of online communities. Barcelona Publishers.
- Giddens, A. & Griffiths, S. (2000). *Sociology*. Alianza Editorial, Issue 4.
- Gielen, S., Peeters, E., Dochy, F., Onghena, P. & Struyven, K. (2010) Improving the effectiveness of peer feedback for learning. *Learning and Instruction*, 20, 304–315.
- Goh, K. & Watt, E. 2003. From 'dependent on' to 'depended on': The experience of transition from student to registered nurse in a private hospital graduate program. *Australian Journal of Advanced Nursing*. 21(7), 14–20.
- Good, B. (1994). *Medicine, rationality and experience: An anthropological perspective*. Cambridge: Cambridge University Press.
- Grant, E., Ives, G., Raybould, J. & O'Shea, M. (1996) Clinical nurses as teachers of nursing students. *Australian Journal of Advanced Nursing*. 14(2), 24–30.
- Grealish, L. & Smale, L. A. (2011). Theory before practice: Implicit assumptions about clinical nursing education in Australia as revealed through a shared critical reflection [online]. *Contemporary nurse: A Journal for the Australian nursing profession*, 39(1), 51–64.

Appendices

- Greenwood, J. (2000). Critique of the graduate nurse: an international perspective. *Nurse Education Today*, 20(1), 17–29.
- Haggman-Laitila, A., Elina, E., Riitta, M., Kirsi, A. & Leena, R. (2007). Nursing Students in clinical practice – Developing a model of clinical supervision. *Nurse Education in Practice*, 7, 381 – 391.
- Hammersley, M. & Atkinson, P. (2004). *Ethnography*. Research methods. Penguin Putnam Inc.
- Harvath, T. A., Flaherty-Robb, M., White, D. L., Talerico, K. A. & Hayden C. (2007). Best practices initiative: Nurturing partnerships that promote change. *Journal of Gerontological Nursing*, 33, 19–26.
- HealthWorkforce Australia. (2011). Clinical supervision support program directions paper. (Health Workforce Australia), www.hwa.gov.au/sites/uploads/clinical-supervision-supportprogram-directions-paper-april-2011.pdf
- Heath, P. (2002). Our duty of care. National Review of Nursing Education, Department of Education, Training and Youth Affairs, viewed 1 March 2005.
- Henderson, A., Heel, A., Twentyman, M. & Lloyd, B. (2006). Pre-test and post-test evaluation of students' perceptions of a collaborative clinical education model on the learning environment. *Australian Journal of Advanced Nursing*, 23(4), 8–13.
- Hill, W. F. (2002) *Learning: A survey of psychological interpretation* (7th ed) Allyn and Bacon: Boston, MA.
- Hildreth, P. & Kimble, C. (2006). Knowledge networks: Innovation through communities of practice. Idea Group Inc (IGI).
- Hoge, M. A., Huey, L. Y. & O'Connell M. J. (2004). Best Practices in Behavioral Health Workforce Education and Training. *Administration and Policy in Mental Health*, Vol. 32, No. 2, November
- Holloway, I. & Wheeler, S. (1996). *Qualitative research for Nurses*. Blackwell Science: Oxford.
- Hopson, R. & Dixon, A. (2011). Intersections, theories, and meanings of race, racism, and educational ethnography. *Ethnography and Education*, 6(1),.
- Huberman, M. A. and Miles, M. B. (2002) *The Qualitative Researcher's Companion*. Sage Publications: London.
- Hunter, C. L., Spence, K., McKenna, K. & Ledema, R. (2008). Learning how we learn: An ethnographic study in neonatal intensive care unit. *Journal of Advanced Nursing*, 62(6), 657–664.
- Johnstone, B. (2010). *Dell Hymes and the Ethnography of Communication*. Carnegie Mellon University.
- Kaufman, D. M. (2003). *Applying Educational Theory in Practice*. BMJ, 326–213.
- Kimble, C., Hildreth, P. & Bourdon, I. (2008). Communities of practice: Creating learning environments for educators. Wiley Publishers.
- Kirschling, J. & Ives Erickson, J. (2010). The STTI practice–academe innovative collaboration award: Honoring innovation, partnership, and excellence. *Journal of Nursing Scholarship*, 42, 286–294.
- Koh, L.C., 2002. The perceptions of nursing students of practice based teaching. *Nurse Education in Practice* 2 (1), 35–43.
- Kolb, D. (1999). *The Kolb learning style inventory*. (3rd ed.) Boston: Hay group.

Appendices

- Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice-Hall.
- Kostere, L. & Percy, W. H. (2006). *Qualitative research approaches in psychology*. Minneapolis, MN: Capella University.
- Kruger, T., Davies, A., Eckersley, B., Newell, F. & Cheredinichenko, B. (2009). *Effective and Sustainable University-School Partnerships. Beyond determined efforts by inspired individuals*. Teaching Australia: Canberra.
- Lait, J., Suter, E., Arthur, N. & Deutschland, S. (2011). Inter-professional mentoring: Enhancing students' clinical learning. *Nurse Education in Practice*, 11(3), 211–215.
- Laferriere, T. (2005). *The networked learning communities for the benefit of education*. Encounters on Education, (vol 6). Madrid: Scardamalia.
- Lambert, V. & Glacken, M. (2005). Clinical education facilitators: A literature review. *Journal of Clinical Nursing*, 10(2), 664–673.
- Lathlean, J. (1995). *The Implementation and Development of Lecturer Practitioner Roles in Nursing*. Doctor of Philosophy thesis, University of Oxford, Steeple Aston: Ashdale Press.
- Lave, J., & Wenger, E. (1991). Situated learning: Legitimate peripheral participation. Cambridge, England: Cambridge University Press.
- Lave, J. & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: Cambridge University Press.
- Lawrence, K. (2007). Submission to the NBV. Introduction of the flexible Clinical Model. Unpublished.
- Lee, W. S., Cholowski, K. & Williams, A. K. (2002) Nursing students' and clinical educators' perceptions of characteristics of effective clinical educators in an Australian university school of nursing. *Journal of Advanced Nursing*, 39(5) 412–20.
- Leonard, D.C. (2009). *Learning theories A to Z*. Westport, CT: Greenwood Press.
- Levett-Jones T. L, (2005). Self-directed learning: Implications and limitations for undergraduate nursing education, *Nurse Education Today*, 25 363-368
- Levett-Jones, T. & Lathlean, J. (2008). Belongingness: A prerequisite for nursing students' clinical learning. *Nurse Education in Practice*, 8, 103–111.
- Levett-Jones, T., Lathlean, J., Higgins I. & McMillan, M. (2009). Staff—Student relationships and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing*, 316–324.
- Levett-Jones, T. Lathlean, J. Higgins, I. & McMillan, M. (2009a) The duration of clinical placements: A key influence on nursing students' experience of belongingness. *Australian journal of advanced nursing*, 26(2),
- Levett-Jones, T., Lathlean, J., Higgins, I., & McMillan, M. (2009b). Staff-student relationships and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing*, 65(2), 316–324.
- Levett-Jones, T., Parsons, K., Fahy, K. & Mitchell, A. (2006). Enhancing nursing students' clinical placement experiences: A quality improvement project. *Contemporary Nurse*, 23(1), 58–70.
- Lindgren, B. & Athlin, E (2010). Nurse lecturers' perceptions of what baccalaureate nursing students could gain from clinical group supervision. *Nurse Education Today*, 30, 360–364.

Appendices

- Lloyd, S. & Bristol, S. (2006). Modelling mentorship and collaboration for BSN and MSN students in a community clinical practicum. *Journal of Nursing Education*, 45(4), 129–32.
- Löfmark, A., Thorkildsen, K., Råholm, M-B. & Natvig, G. K. (2012). Nursing students' satisfaction with supervision from preceptors and teachers during clinical practice. *Nurse Education in Practice*. 12(3), 164–169.
- Madhavanprabhakaran, G. K., Shukri, R. K., Hayudini, J. & Narayanan, S. K. (2013). Undergraduate Nursing Students' Perception of Effective Clinical Instructor: Oman. *International Journal of Nursing Science*. 3(2): 38 – 44
- Malloch, M., Cairns, L. Evans, K. & O'Connor, B. (2011). *The SAGE Handbook of Workplace Learning*. Sage: Los Angeles.
- Manninen, K., Welin Henriksson, E., Scheja, M. & Silen, C. (2013) Authenticity in learning—nursing students' experiences at a clinical education ward. *Health Education*, 113(2), pp
- Martin, H. E., (1957). *Surgery of head and neck tumors*. London: Cassell.
- MacIntyre, R. C., Murray, T. A., Teel, C. S. & Karshmer, J. F. (2009). Five recommendations for prelicensure clinical nursing education. *Journal of Nursing Education*, 48(8), pp
- McCarthy, B. and Murphy, S. 2007. *Assessment of student nurses in clinical practice*. Nurse Education Models. Conference: University College Cork Ireland. http://stti.confex.com/stti/congrs07/techprogram/paper_34007.htm (accessed 15.05.2013).
- McKenna, L.G. & Wellard, S. (2004). Discursive influences on clinical teaching in Australian undergraduate nursing programs. *Nurse Education Today* 24, 229–235.
- McKenna, L.G., Wray, N. & McCall, L. (2007). Exploring continuous clinical placement for undergraduate students. *Advances in Health Science Education*.
- McKenna, L. G., Wray, N. and McCall, L.(2008) *Exploring continuous clinical placement for undergraduate students*. *Adv Health Sci Educ Theory Practice*
- McKown, T., McKown, L. & Webb, S. (2011). Using quality and safety education for nurses to guide clinical teaching on a new dedicated education unit. *Journal of Nursing Education*, 50(12), 706-710.
- Morgan, DL Krueger, RA King, JA and Scannell AU 1998, *Focus Group Kit*. Sage, Thousand Oaks, CA.
- Moscato, S. R., Miller, J., Logsdon, K., Weinberg, S. & Chorpenning, L. (2007). Dedicated education unit: An innovative clinical partner education model. *Nursing Outlook*. 55(1), 31–7.
- Mullenbach, K.F. & Burggraf, V. (2012). A dedicated learning unit in long-term care: A clinical immersion for student nurses. *Geriatric Nursing*, 33(1), 63-67.
- Moule, P., Ward, R. & Lockyer, L. (2011). Issues with e-learning in nursing and health education in the UK: Are new technologies being embraced in the teaching and learning environments? *Journal of Research in Nursing*, 16(77), pp
- Murray, T., Crain, C., Meyer, G., McDonough, M.E., & Schweiss, D. (2010). Building bridges: An innovative academic-service partnership. *Nursing Outlook*, 58, 252–260.
- Murray, T. & James, D. (2012). Evaluation of an academic service partnership using a strategic alliance framework. *Nursing Outlook*, article in press, 1-6.

Appendices

- Murray, T.A., MacIntyre, R.C. & Teel, C.S. (2011). An analysis of the partnership performance: The St Johns Mercy Medical Centre-Saint Louis University School of Nursing dedicated education unit project. *Journal of Professional Nursing*, 27(6), e58-e63.
- Myrick, F. & Yonge, O. (2004). Enhancing critical thinking in the preceptorship experience in nursing education. *Journal of Advanced Nursing*, 45(4), 371–380.
- National Health Workforce Taskforce (2009). Clinical training: governance and organisation, February 2009.
- National Health Workforce Taskforce (2008). Health Education and Training, Clinical Placements across Australia: Capturing Data and Understanding Demand and Capacity. A Discussion Paper. NHWT, Melbourne, Vic
- Newton, J. M., Billett, S. & Ockerby, C. M. (2009). Journeying through clinical placements—An examination of six student cases. *Nurse Education Today*, 29, 630–634.
- Nehls, N., Rather, M. & Guette, M. (1997). The preceptor model of clinical instruction: The lived experience of students, preceptors and faculty-of-record. *Journal of Nursing education*, 36 (5): 220 – 227.
- Nichter, M. (1993). Social-science lessons from diarrhea research and their applications to Ari. *Human Organization*, 52(1), 53–67.
- Niederhauser, V.; Macintyre, R. C.; Garner, C., Teel, C., Murray, T. A. (2010). Future of nursing. Transformational partnerships in nursing education. *Nursing Education Perspectives*, 31(6), 353–5.
- Nightingale, F. (1893/1949). Sick nursing and health nursing. In I. Hampton (Ed.), *Nursing the Sick – 1893* (pp. 24-43). New York: McGraw-Hill.
- Nightingale, F. (1895). Nursing: Training of. In R. Quain (Ed). *A Dictionary of Medicine* (pp. 231-2374). New York; D. Appleton and Company
- Nolan, C. 1998. Learning on clinical placement: The experience of six Australian student nurses. *Nurse Education Today*. 18(8):622-629.
- Nursing Education in Australian Universities: Report of the National Review of Nurse Education in the Higher Sector – 1994 and Beyond (1994). Australian Government Publishing Service: Canberra, Australia.
- Nurses Board of Victoria, *Guidelines: Delegation and supervision for registered nurses and midwives*. Retrieved 3 December 2008. Available from: http://www.nbv.org.au/c/document_library/get_file?p_l_id=10327&folderId=13486&name=DLFE-359.pdf.
- Nurses Board of Victoria, *Principles Regarding Shifts Undertaken During Clinical Placement*. Retrieved 3 December 2008. Available from: http://www.nbv.org.au/c/document_library/get_file?p_l_id=10327&folderId=13486&name=DLFE-365.pdf.
- O'Reilly, K. (2008). *Key Concepts in Ethnography*. Sage: London
- O'Brien, L., Buxton, M. & Gillies, D. (2008). Improving the Undergraduate Clinical Placement Experience in Mental Health Nursing. *Issues in Mental Health Nursing*, Volume 29, Issue 5 May 2008, pages 505 – 522
- O'Donovan, M., 2006. Reflecting during clinical placement – discovering factors that influence pre-registration psychiatric nursing students. *Nurse Education in Practice* 6, 134–140.

Appendices

- O'Donoghue, T. and Punch, K. (2003). *Qualitative Educational Research in Action: Doing and Reflecting*, London, Routledge Falmer
- O'hring, K., Hallberg, I. (2001). The meaning of preceptorship: nurses' lived experience of being a preceptor. *Journal of Advanced Nursing* 33, 530–540.
- Ogle, K. R., Bethune, E., Nugent, P. and Walker, A. (2002) *Nursing Education and Graduates: Stage 2 (2002)*. Canberra: National Review of Nursing Education
- Ohring, K. & Hallberg, I. R. (2000). The meaning of preceptorship: Nurses' lived experience of being a preceptor. *Nursing*, 33(4), pp
- Pallaruelo, S. (2000). *Joseph, a man of the Pyrenees*. Prames: Zaragoza.
- Papalia, D.E. (2009). *Human development* (11th ed). New York: McGraw Hill
- Papp, I., Markkanen, M. & von Bonsdorff, M. (2003). Clinical environment as a learning environment: student nurses' perceptions concerning clinical learning experiences. *Nurse Education Today*, 23 pp. 262–268
- Pearcey P. A., Elliott, B. E., 2004. Student impressions of clinical nursing. *Nurse Education Today* 24, 382–387.
- Polit, D. F. & Beck, C. T. (2004). *Nursing research: Principals and methods*. (7th ed.) Lippincott: Philadelphia.
- Rankin, J. M. & Campbell, M. (2009) Institutional ethnography, nursing work and hospital reform. *Qualitative social Research*, 10(2), pp
- Ranse, K. & Grealish, L. (2007). Nursing students' perceptions of learning in the clinical setting of the dedicated education unit. *Journal of Advanced Nursing*, 58(2), 171–179
- Rapport, F. & Maggs, C. (1997). Measuring care: The case of district nursing. *Journal of advanced Nursing*, 25, 637–680.
- Rashleigh, L., Cordon, C. & Wong, J. (2011). Creating opportunities to support oncology nursing practice: surviving and thriving. *Cancer Oncology Nursing Journal*, 21(1), 7–15
- Redmond, B. (2004). *Reflection in Action: Developing Reflective Practice in Health and Social Services*. Ashgate Publishing Ltd: Aldershot.
- Reilly, D., & Oermann, M. (1992). *Clinical teaching in nursing education* (2nd ed.). New York: National League for Nursing.
- Richardson, V., Fentiman, B., Nash, B., Lemcke P., & Varkararawa J. (2000). The clinical education unit: An enhanced learning context for undergraduate nursing students. In *Flexible Learning for a Flexible Society*, Proceedings of ASET-HERDSA 2000 conference, Toowoomba, Qld, Australia, 2–5 July.
- Rolfe, G., Freshwater, D. & Jasper, M. (2002). *Critical reflection for nursing and the helping professions: A users guide*. MacMillan: Basingstoke.
- Royal College of Nursing. (2008) *Spinning plates: Establishing a work-life balance*. RCN: London.
- Ryan, A., Goldberg, L. & Evans, J. (2009). Wise women: Mentoring as relational learning in perinatal nursing practice. *Journal of Clinical Nursing*. 19(1–2), 183–191.
- Saint-Onge, H. & Wallace, D. (2003). *Leveraging Communities of Practice*. Butterworth Heinemann.
- Sax, S. (1978). *Nurse education and training: report of the committee of enquiry into nurse education and training*. Canberra: AGPS.

Appendices

- Schon, D. (1983). *The reflective practitioner: How professionals think in action*. Basic Books: New York.
- Schnieder, Z., Whitehead, D. & Elliot, D. (2007). *Nursing & Midwifery research. Methods and appraisals for evidenced-based practice*. (3rd ed). Elsevier: Sydney.
- Schupbach, J. E. MS, MA (2012) *Strategies for Clinical Teaching*. Audiology online. Located at: <http://www.audiologyonline.com/articles/strategies-for-clinical-teaching-6944>. Retrieved 4 April 2013.
- Scully, N. J. (2011). The theory-practice gap and skill acquisition: An issue for nurse education. *The Australian Journal of Nursing Practice. Scholarship and Research*. 18 (2), 93 - 98
- Shah, H. S. & Pennypaker, D. R. (1992). The Clinical teaching partnership. *Nurse Educator*, 17(2), 10–12.
- Smedley, A. & Morey, P. (2010). Improving learning in the clinical nursing environment: Perceptions of senior Australian bachelor of nursing students. *Journal of Research in Nursing*, 15(75), 75–88.
- Spencer J. 2003. Learning and teaching in the clinical environment. *Br Med J* 326:591–594.
- Spouse, J (2001), Bridging theory and practice in the supervisory relationship: a sociocultural perspective. *Journal of Advanced Nursing*.33(4) 512–522
- Spradley, J. (1980). *Participant observation*. New York: Holt, Reinhart & Winston.
- Streubert, H. J. & Carpenter, D. R. (1995). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia: J. B. Lippincott Company.
- Somerville, D. and Keeling, A. (2004) [A practical approach to promote reflective practice within nursing](http://www.nursingtimes.net/nursing-practice/204502.article) [online] Available from: <http://www.nursingtimes.net/nursing-practice/204502.article> [accessed: 10th June 2011].
- Taylor, B. (2000). *Reflective practice: A guide for nurses and midwives*. St Leonards: Allen & Unwin.
- Taylor and Francis group located at www.tandf.co.uk. Retrieved 2 May 2012.
- Taylor, B. (2000). *Reflective practice: A guide for nurses and midwives*. St Leonards: Allen & Unwin.
- Timmins, F. (2012). Nurse education in practice 2001–2011: An examination of a decade of progress. *Nurse education in Practice*. Elsevier: online 3 February.
- Vygotsky, L. (1978). *Mind in society: The development of higher mental processes*. Cambridge, Ma: Harvard University press.
- Waters, A. (2008). Nursing attrition is costing UK tax payers £99 million a year. *Nursing Standard*. 22(31),
- Watson R, and Thompson D (2008) Asymmetrical professors unbalanced or misunderstood? *Nurse Education in Practice*. 8, 2, 73-75.
- Webb, C. (2003). Editor's note: Introduction to guidelines on reporting qualitative research. *Journal of Advanced Nursing*, 42(6), 544–545.
- Wellard, S.J., Williams, A. & Bethune, E. (2000). Staffing of undergraduate clinical learning programs in Australia. *Nurse Education Today*, 20, 548–554.
- Wellman, S. (1999). *Florence Nightingale : Lady with the lamp*. Barbour: Barbour.
- Wenger, E., McDermott, R & Snyder, W. M. (2002). *Cultivating Communities of Practice*. HBS press.

Appendices

- Wenger, E. (2010). *Communities of Practice: A brief introduction*. Learning SA TfEL: Curriculum services, DECS.
- Wenger, Etienne (1998) 'Communities of Practice. Learning as a social system', *Systems Thinker*, <http://www.co-i-l.com/coil/knowledge-garden/cop/lss.shtml>. Accessed April 30 2014
- Wenger, E., McDermott, R., & Snyder, W. M. (2003). *Cultivating communities of practice*, Boston: Harvard Business School Press.
- Williams, A. F., Wellard, S. J. & Bethune, E. (2001). Assessing Australian undergraduate clinical learning. *Collegian*, 8(4), 9–13.
- Williamson, S., Twelvetree, T., Thompson, J. & Beaver, K. (2012). An ethnographic study exploring the role of ward-based advanced nurse practitioners in an acute medical setting. *Journal of Advanced Nursing*. 68(3) online,
- Wilson, B. G & Cole, P. (1991). Cognitive dissonance as an instructional variable. *Ohio Media Spectrum*, 43(4), 11–21.
- Winter-Collins, A. & McDaniel, A. M (2000). Sense of Belonging and New Graduate Job Satisfaction. *Journal for Nurses in Staff Development*, 16(3), 103–111.
- Wolff AC, Pesut B, Regan S. (2010). New graduate nurse practice readiness: perspectives on the context shaping our understanding and expectations. *Nurse Education Today*. 30:187–191
- Wotton, K., & Gonda, J. (2004). Clinician and student evaluation of a collaborative clinical teaching model. *Nurse Education in Practice* 4 (2), 120–127.
- Yonge, O., Myrick, F., Ferguson, L., & Lughana, F. (2005). Promoting effective preceptorship experiences. *Journal of Wound, Ostomy, and Continence Nursing*, 32(6), 407–412.

Appendices

Appendix 1: Information for Participants

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH (students)

You are invited to participate

You are invited to participate in a research project entitled:

Developing an Innovated Flexible Clinical Education Model: Enhancing Student Learning

This project is being conducted by a Higher Degree Research (HDR) student, Karen Lawrence as part of a Doctor of Education at Victoria University under the supervision of Associate Professor Colleen Vale and Dr. Marcelle Cacciattolo from Faculty of Arts, Education and Human Development.

Project explanation

The aim of this study is to explore how a partnership between faculty and nursing staff in the hospital unit can provide a synergistic environment to better educate the next generation of nurses. It will also explore how the Flexible Clinical Education Model (FCEM) may enable students to develop a sense of satisfaction with their clinical learning experience.

What will I be asked to do?

Undergraduate nursing students (15 in total)

- Be observed interacting with a clinical preceptor during an eight week period at **Hospital X**.
- Participate in a focus group interview lasting no more than one hour at **Hospital X**.
- Give permission for your journal entries on WebCT to be viewed and downloaded

What will I gain from participating?

Appendices

It is anticipated that this study will facilitate an experience in which students feel their contributions are valued and causative in generating a new body of knowledge and support for nursing students, clinical and academic staff.

The immediate benefits to students are minimal in the research study; however over the longer term participants may benefit by being better prepared for future clinical placements while they complete the Bachelor of Nursing. Students may also benefit long term (when they are graduates) by developing an understanding of the importance of a positive professional relationship between ward staff and students.

How will the information I give be used?

Information obtained from this study may be disseminated through publications or conference presentations. Every effort will be taken to ensure participants are not identifiable. The findings will be reported in a doctoral thesis.

What are the potential risks of participating in this project?

- In the course of the interview, you may feel troubled when discussing teaching situations that they have experienced.
- During the observation, you may feel intimidated by having the HDR student watching.
- You may feel anxious that your assessment or grading could be affected by the outcome of either the observation or interview.
- You may feel obligated to participate.
- You may feel uncomfortable sharing their ideas and opinions about their learning and experience in front of their peers.
- You may feel alienated by other students who are not involved in this study.
- You may believe their academic achievements may be affected by participating or not participating in the FCEM

While these potential risks have been identified, it is anticipated that the research approach to be used will enable you to feel your contributions are valued and will contribute to generating a new body of knowledge and support for nursing students, clinical and academic staff.

You will be fully informed about the purpose of the study and the way in which information will be used. You will be advised that:

- (i) participation is voluntary; and
- (ii) You can choose not to answer any question that might cause discomfort.
- (iii) You will be advised to offer only that information which you are comfortable to share with others
- (iv) You will be advised not to answer questions, which are uncomfortable for you.
- (v) All data will be de-identified after collection.
- (vi) No coercion from the HDR student will be used to encourage you to take part or remain in the study
- (vii) You may withdraw from the research at any time.

Anne Graham is a Psychology counsellor at Victoria University. Should you feel troubled by your participation in this research project Anne will provide counselling to you. Her phone number is 99192159.

How will this project be conducted?

This study will commence September 1st and conclude November 30th 2010. There will be three groups of participants: undergraduate nursing students; clinical ward staff (**Hospital X**) and academic staff (Victoria University).

- The HDR student will forward information about the dates and times of observations by email to all participants at the commencement of the clinical practice.
- The HDR student will spend up to two hours across the four wards that are participating in the FCEM at **Hospital X**, commencing September 1st and concluding November 30th 2010
- The first observation session is scheduled for Wednesday 1st September between 0900 – 1100 hours.
- During the observation the HDR student will be observing the activities of the student and preceptor and interactions between them.
- After the last observation session, the researcher will contact each participant to arrange a time to meet with students to undertake a focus group interview.
- The HDR student will contact the coordinator of the clinical unit HNB3250 Clinical Practicum 9: Consolidation, to arrange access to WebCT following completion of the unit, completion of all assessment for the unit and submission of results for this unit.

Who is conducting the study?

Details of the Principal Researcher:
Associate Professor Colleen Vale
School of Arts, Education and Human development
9919 4893

Details of the Higher Degree Student:
Karen Lawrence
School of Nursing & Midwifery
9919 2462

Any queries about your participation in this project may be directed to the Principal Researcher listed above.

If you have any queries or complaints about the way you have been treated, you may contact the Ethics and Biosafety Coordinator, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4148.

Appendix 2 Request to attend orientation

Request to attend orientation

Dear

I am writing to you in my capacity as a doctoral student at Victoria University and the information I am collecting will be used in my thesis. The purpose of this letter is to request your approval attend the upcoming orientation day for the 3rd year nursing students.

Hospital X has been specifically chosen as the site to undertake my research study, "Developing an innovated Flexible Clinical Education Model: Enhancing Student Learning".

The aim of this study is to explore how a partnership between faculty and nursing staff in the hospital unit can provide a synergistic environment to better educate the next generation of nurses. It will also explore how a Flexible Clinical Education Model (FCEM) may enable students to develop a sense of satisfaction with their clinical learning experience.

A better understanding of what constitutes quality clinical education from the students and practitioners' perspective would be valuable in providing better educational experiences. A more rigorous study of this flexible model will add value for nursing education and future research by exploring avenues that enhance students and practitioners' experience of clinical practice.

Ethics approval has been sought and granted from Victoria University HRETH 10/131 and approval is currently been sought through Melbourne Health HREC project code 2010.169.

In this session, I will be providing the students with an overview of my study and what they would be required to do if they choose to participate.

Please contact me using the details below so we can set up a suitable time to meet.

Kind regards

Karen Lawrence
Student researcher

Phone 61 3 9919 246
Email Karen.Lawrence@live.vu.edu.au

Appendix 3 Participant Observation template

Date: Ward: Student: Preceptor:						
Physical setting.	Activities.	Human, social environment.	Formal interactions.	Informal interactions and unplanned activities	Nonverbal communication.	Observing what does not happen.
Describe the setting. This may include drawings of the space and furniture arrangement.	Describe the activities that took place in that setting. Reproduce the sequence of actions and behaviours	Describe the people who took part in the activities and their roles in the activities.	Describe the meaning of what was observed between participants in their role as Nurse/patient	Describe the meaning of what was observed between participants as people rather than their roles	Eye contact Non-verbal gestures Body language	Things that I would expect to happen, introductions to patient from student or preceptor
<p>General Comments:</p> <p>How many shifts student has completed</p> <p>How many times student has worked with this preceptor</p> <p>Describe any impact you might have had on the situation you observed.</p>						

Appendix 4: Excerpt from transcribed field notes

Wednesday, 3rd of November.

Observation number 3. Ward 2C. Student,* Preceptor: *

Today's activity was medication administration. The physical setting was a four-bed ward. It was noted that all patients in this room were women. The room as well-lit. The blinds were open and all curtains were pulled back, so it was very bright and light. The patient that we were observing was in the first corner on the left and it was quite congested around her bedside. There was a walking frame. The patient was sitting in a chair with the walking frame in front of her. There was a bedside table at the end of her bed. There was a bedside chest of drawers that was beside her bed, and there was another chair in there as well beside the patient. So by the time the student and a registered nurse got in there as well, there was very little room for movement. It was quite congested.

It was also lunch time and there was a very strong aroma of the four patients' lunch in the room, and this patient's lunch was still sitting on the overhead table with the covers over the food, but still the aromas were quite strong.

Appendix 5: Interview questions for student Focus Groups

Research question

1. *How can the Flexible Clinical Education Model allow nursing students' learning to be central and valued?*

Contributing questions:

- How can the Flexible Clinical Education Model provide nursing students with satisfaction of their clinical experience?
- How can the Flexible Clinical Education Model practice a genuine partnership between academics and clinical agencies?
- How can the Flexible Clinical Education Model provide academics and clinicians who are well prepared to meet the objectives of student placements?
- How can the Flexible Clinical Education Model be sustainable within the Bachelor of Nursing?

Examples of questions for focus groups include:

- Describe your latest clinical education experience in the surgical/medical ward at **Hospital X** (ie. Flexible Clinical Education Model practice).
- Who or what factors contributed to your experience?
- Would you give me an example that illustrates how this contributed to your experience?
- What have you learned about nursing practice?
- Can you give me an example and tell me how this happened.
- What have you learned about the nursing profession?
- Can you give me an example and tell me how this happened.

Appendix 6 Interview questions for academic staff

Key Question:

How can the Flexible Clinical Education Model allow nursing students' learning to be central and valued?

Contributing questions:

1. How can the Flexible Clinical Education Model provide nursing students with satisfaction of their clinical experience?
2. How can the Flexible Clinical Education Model practice a genuine partnership between academics and clinical agencies?
3. How can the Flexible Clinical Education Model provide academics and clinicians who are well prepared to meet the objectives of student placements?
4. How can the Flexible Clinical Education Model be sustainable within the Bachelor of Nursing?

Examples of questions for academic staff include:

- Describe your experience of the Flexible Clinical Education Model. What has contributed to this experience?
- Who or what factors contributed to your experience? Would you give me an example that illustrates how this contributed to your experience?
- Describe the relationship between clinical and academic staff. How does this differ from a block model? Can you give me an example that illustrates the relationship differences/similarities?
- How do you believe the Flexible Clinical Education Model has developed a partnership between **Hospital X** and Victoria University? Can you give me an example and tell me how this happened?
- How were you provided with preparation to undertake this model? What did you find most useful about the preparation you received? Would you give me an example that illustrates how this contributed to your experience?
- What would be the advantage/disadvantage of continuing with the Flexible Clinical Education Model? Would you give me an example of how the Flexible Clinical Education Model be sustained within the Bachelor of Nursing? Would you give me some examples that illustrate how it can be sustainable?

Appendix 7: Interview questions for Preceptors

Key Question:

How can the Flexible Clinical Education Model allow nursing students' learning to be central and valued?

Contributing questions:

1. How can the Flexible Clinical Education Model provide nursing students with satisfaction of their clinical experience?
2. How can the Flexible Clinical Education Model practice a genuine partnership between academics and clinical agencies?
3. How can the Flexible Clinical Education Model provide academics and clinicians who are well prepared to meet the objectives of student placements?
4. How can the Flexible Clinical Education Model be sustainable within the Bachelor of Nursing?

Examples of questions for ward staff include:

- Describe your experience of the Flexible Clinical Education Model. What has contributed to this experience?
- Who or what factors contributed to your experience? Would you give me an example that illustrates how this contributed to your experience?
- Describe the relationship between students and staff. How does this differ from students completing a block model? Can you give me an example that illustrates the relationship differences/similarities?
- How do you believe the Flexible Clinical Education Model has developed a partnership between **Hospital X** and Victoria University? Can you give me an example and tell me how this happened?
- How were you provided with preparation to undertake this model? What did you find most useful about the preparation you received? Would you give me an example that illustrates how this contributed to your experience?

Appendix 8 Daily Preceptor's Notes

Preceptor Notes

Student: _____

Date	Preceptor Comment	PreceptorName & Signature