

**The Work, Preparation and Development of Nursing Clinical
Teachers.**

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Abstract

Clinical teachers play an important role in the education of student nurses within the practicum part of their course. Clinical teachers are usually experienced clinical nurses who are recruited into this role, often with little preparation. Examined in this thesis are those nurses employed as clinical teachers by educational institutions, in particular the complexities of their role, their preparation and how they develop into experienced and expert clinical teachers. More needs to be known about their development beyond being a novice clinical teacher. The aim of the thesis was therefore to explore the development of clinical teachers along with the complexities of their role to see how this could assist in the development of new, and ongoing, clinical teachers, thus leading to a better learning experience for nursing students.

A qualitative methodology was used to explore the work of clinical teachers. An iterative process of plan, implement and review was used to develop the content of seven workshops for clinical teachers, while a case study approach was used to investigate the experiences of clinical teachers and second year nursing degree students. Data collection methods included participant observation, conducted at the workshops, analysis of clinical assessment forms, interviews with a group of clinical teachers, and focus group interviews with student nurses.

The analysis of the data has shown that the role of the clinical teacher is a complex one. Three main roles were identified: a facilitative role, an educative role and an assessment role. Engeström's (1999) knotworking is used to help understand, in particular, the complexities of the facilitative role of the clinical teacher. The three roles have been conceptualised in a model of how clinical teachers develop, based on Benner's (1984) novice to expert model. Recommendations are made which could promote the development of expertise among clinical teachers in both local and more general contexts.

Student Declaration

Doctor of Education Declaration

“I, Clive Leslie Miller, declare that the EdD thesis entitled The Work, Preparation and Development of Nursing Clinical Teachers 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”.

Signature

Date 2/1/2013

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Glossary

ANMC – Australian Nursing and Midwifery Council. An organisation that has produced national Competency Standards for Registered and Enrolled nurses as well as codes of Ethics and Professional Conduct for nurses. The competency standards have a variety of uses including being used for the assessment of student nurses while on clinical practice. This use is mandated by course accreditation bodies.

AQF – Australian Qualification Framework

Bondy scale – an assessment scale for student nurses originally developed by Kathleen Bondy (1983) in the early 1980's. It is a criterion reference system used by many Schools of Nursing in their clinical assessment tools.

Buddy nurse – Where the student is working with a clinical teacher the clinical teacher cannot supervise the student all of the time as they have up to 7 other students to also supervise. The process is that a nurse on each shift is responsible for supervising the student when the clinical teacher is not present; this nurse is called the student's "buddy" nurse. They retain overall responsibility for the patients allocated to them and the student. They are not responsible for assessment of the student but may give feedback to the clinical educator about the students' abilities and work.

Clinical challenge – A process used with a failing student where they are given specific objectives, related to areas where they are underperforming, and given an amount of time to improve in those areas or else they will be removed from the placement and given a fail grade

Clinical educator – term used to describe any educator that works in the clinical field. It will only be used where there does not seem to be another appropriate term to use to describe the person and/or their role.

Clinical placement agency – another term for a Clinical venue

Clinical Practicum – The time spent by the student in a clinical setting as part of their course. In the case of the placements in this study they were a separate unit of study while in other education institutions this time may be incorporated into theory units.

The students are placed in any area where registered nurses work and usually commence in low acuity areas where mainly basic nursing skills are used and over the course the students move to higher acuity areas such as Emergency Departments and specialist areas such as neurosurgery. Some areas can be mandated by the registration authorities, as in the case of the course current at the time the data were collected where aged care and mental health placements were required for course accreditation.

Clinical teacher –used to describe clinical educators, employed on a contractual and/or sessional basis by the University to work with students who are on clinical placement. Nursing Board requirements in Australia are that the clinical teacher (whichever term is used for them) has no more than 8 students to supervise. They work with a group of students who may be spread over several clinical areas within a clinical venue. They may know the clinical venue well or it may be the first time they have been there.

Clinical venue – a place where students undertake clinical experience. They can range from large metropolitan hospital to small GP clinics and community based teams; anywhere where healthcare is provided that involves Registered nurses.

CLO – Clinical Learning Office, this is the section of the school that deals with the administrative aspects of student placements and Clinical Teachers. They are responsible for student placements, making this information available to students, academic staff, clinical teachers and placement venues. They also arrange the contracts for clinical teachers and the legal agreements with clinical venues.

Course – the work undertaken to gain the degree. Three years of work made up of multiple units of study.

CPAF – Clinical Practicum Assessment Form – Form used to document the students progress on the clinical placement. Both a formative and summative assessment is carried out and documented. Separate forms were used for these assessments during the data collection period for this work.

CPAT – Clinical Practicum Assessment Tool – Later name for CPAF document (see above).

Enrolled Nurse (E/N) (was called Division 2 Nurse at the time of the data collection) – A nurse with the basic qualification of a Cert IV in Nursing. The current requirement for registration as an Enrolled nurse is now a diploma in nursing.

Flexible Clinical Model – A clinical placement model where the students are placed in a clinical venue for a prolonged placement period (14 to 16 weeks) and they, at the time of the study, self roster one or two shifts a week until they have met the placement requirements.

Graduate nurse – A new registered nurse in their first year after registration and undergoing a program within a workplace to help them further develop their skills supported by mentors and educators.

Hospital clinical educator – This term is used for clinical placement agency employed staff who work as clinical teachers for students on placement. These staff often work for the clinical placement agency within their education department or are clinical staff seconded to the clinical placement agency education department to act in this role while students are present.

Nurses Board of Victoria – the registration body for Registered and Enrolled nurses (using the term Division 1 and Division 2 Registered nurses) and also responsible for course accreditation at the time the data for this study was collected.

Preceptor – A term used for a nurse who works with a student over a period of time. The student will usually work the shifts of the preceptor and the preceptor is the educator and assessor of that student. A preceptor will usually only work with one student at a time. In some cases a group of nurses will act as the preceptor of a student (in particular where these nurses work part time so cannot cover all of the shifts of the student) and within one model of clinical placement it is the ward that acts as the preceptor. This method of supervision is often used in the mental health area.

Registered Nurse (R/N) (was called Division 1 Nurse in Victoria at the time of the data collection) – A nurse with the basic qualification of a Bachelor degree.

Unit – a single area of study undertaken in one semester and having a particular topic focus. There can be four or five units of study in one semester

Unit of Study Coordinator – the academic who is responsible for the running of and coordination of a unit of study

Chapter 1:

The Work, Preparation and Development of Nursing Clinical Teachers: An introduction

Introduction

Nursing clinical teachers are Registered Nurses who supervise a group of nursing students undertaking a clinical placement or practicum as part of their studies.

Educators for practicums need two sets of skills, there is the discipline knowledge of nursing and the nursing profession along with educational knowledge to make them highly accomplished clinical teachers. It is this latter aspect that will be focused upon in this thesis; a focus which also makes the research transferable to a wider audience as many of these skills will be the same or similar regardless of the discipline the students come from.

Within undergraduate nursing education in Australia, as well as other countries, students are required to complete a period of time within the clinical setting to develop their clinical practice. This experience is usually called a clinical practicum. There are a variety of factors that can affect the quality of the placement including the preparation of the students, the appropriateness of the placement for the students' learning needs, the support provided by the placement staff and the quality of the clinical teaching (Courtney-Pratt, FitzGerald, Ford, Marsden, & Marlow, 2012; Papp, Markkanen, & von Bonsdorff, 2003).

Various models are used to support the students while undertaking this clinical practicum. This can be through the use of clinical teachers, often found in North America and Australia (Forbes, 2010; Mallik & Aylott, 2005; Whalen, 2009). In Australia clinical teachers are Registered Nurses (called Division 1 nurses at the commencement of the study) employed by the university either directly, through agencies or via an arrangement with the clinical venue, to supervise a group of students that can be up to eight in number. Alternatively there is the preceptor/mentor arrangement, used to various extents in many countries and which is the principle arrangement in the UK (Mallik & Aylott, 2005; Nursing & Midwifery Council, 2008).

A preceptor/mentor arrangement is where each student is placed with one registered nurse and works with that nurse on a one-to-one basis. At the time and site of this study a preceptor arrangement was in place where only one or two students were placed in a particular venue.

In nursing, as in many other health disciplines and other professional practice disciplines, the length of time that students are required to be in the practical setting as well as the supervisory arrangements are mandated by the registration body. In Victoria, at the time the study was undertaken the registration body was the Nurses Board of Victoria (NBV) (2005) with the requirements set out in its course accreditation document.

The focus of this study is a group of clinical teachers, employed by educational institutions, who work with a group of students. These students are usually spread over a group of wards or areas with each student being buddied with one of the permanent staff members in that ward/area. Due to these arrangements the clinical teacher does not work directly with each student all of the time as they have to move between the different wards/areas. The clinical teacher is responsible for the teaching, guiding, supporting and evaluating of students (Victoria University, 2010).

The clinical teachers normally work in isolation from the University (Hall, Daly, & Madigan, 2010), being placed in the various venues that the students undertake their clinical practicum. In many cases they receive little if any support and preparation from the University (Scanlan, 2001). This disconnection from the academic world provides a weak link in the education of students as the clinical practicum is where students are expected to bring together the theoretical knowledge they have learned in the university with the clinical practice of hands on nursing. Thus the clinical teacher holds a vital role in helping the student bridge the theory – practice gap. Although there is an assumption that knowledge will transfer from the university to the clinical setting for students this is not the case, it being suggested that “the ‘gap’ is underpinned by a strong division of two separate communities” (Newton, Billett, Jolly, & Ockerby, 2009, p. 316). Newton et al. (2009) argue that students only make sense of the theory when they are able to utilise this in practice; “Many students cannot understand, let alone translate, theoretical concepts from reading a text, unless they can relate it to experience” (p. 318). Because of the nature of the two separate communities Newton et al. (2009) talk of translation,

rather than transfer, of knowledge between the two and have identified that when educators help in this translation students gain a deeper understanding of their theory and how this can be applied in the clinical setting. Field (2004), in a discussion of novice to expert, talks about this as ‘situated learning’ rather than a ‘constructivist’ view of learning. In this instance the learning is situated in, and developed from, the students’ immersion in the clinical context and practice.

Scanlan (2001) stated that “Clinical teaching in nursing is a complex phenomenon that lacks a coherent theoretical base and is perplexing to novices” (p. 240). Almost ten years later this thought is still being echoed in this comment; “Little is known about the skill and knowledge acquisition of nurses in the educator role” (Ramsburg, 2010 Abstract). In-between these times Tanner (2005) commented in an editorial that “we have very little research about what factors in the clinical education environment make a real difference in student learning” (p. 151). To date much of the literature has discussed and reported on various aspects of the students’ clinical practicum and the various forms of placement support the students are given (Andrews et al., 2006; Chapman & Orb, 2000, 2001; Gillespie, 2002; Jackson & Mannix, 2001). It is recognized that good support for students leads to a better experience and greater skill development (Gillespie, 2002). There is discussion in the literature on how the clinical teachers/preceptors are supported and developed and the effect these has on student learning and practice although much of the literature repeats previous work or adds little to the knowledge of the phenomenon. It is envisaged that this thesis will add to the limited work on understanding the role and the preparation of Clinical Teachers.

Theoretical aspects of the study

This thesis is centred on workplace learning, that of student nurses and their supervisors, clinical teachers. Hager (2011) has discussed theories in relation to workplace learning and these will help inform aspects of this work. Hager (2011) has talked about them as “psychological theories”, “Socio-cultural theories” and finally “Postmodern theories” although in some instances it is posited that there can be overlap between them. This separation is not supported by all. For example Williams, although he initially talks about “two contrasting theoretical positions” (2001 p. 1), that is psychological and social, goes on to indicate that both can be used where he comments “meaning comes from the internalisation and externalisation of these within the social

context (external) and psychological context (internal) of discourse/activity” (2001 p. 6).

Psychological theories are based around the person or individual and that learning is thought of as being an ‘object’ that can be acquired and transferred. Hager raises some issues with these ideas, in particular is the view that “Learning [is] independent of context” and from this flows the idea that learning is easily transferred from situation to situation (Hager, 2011, p. 22). It can then be asked then that if this is the case then why, in nursing and many of the other professional disciplines do registration and or accreditation bodies require periods, often not insignificant, of clinical practice within the course that leads to registration when students could be taught all the skills and knowledge they need to practice in the education setting?

Hager comments on the novice to expert work of Dreyfus and Dreyfus upon which Benner’s (1984) work, discussed later, is based. Hager states that “All stages of the Dreyfus model are *activity-and experience-based*” (2011, p. 20 emphasis added) and that generally most people will learn by participating in an activity however the general point is that learning is not the main purpose or aim of participation, the learning is incidental. In discussing the Dreyfus work Gardner (2012) comments that “Education for practice therefore requires the student to learn in and from practice alongside more experienced practitioners” thus putting clinical education in the socio-cultural realm (p. 340).

Socio-cultural theories present a different view from psychological theories and as the name suggests they have a social focus to learning. Within this view the individual learner is not the sole focus of attention and that the social aspect of the learning situation needs just as much attention as the learner (Hager, 2011). Hager continues saying that learners develop “by actively engaging in the ongoing processes of [participating in] workplaces, rather than by acquiring a series of specific products” (Hager, 2011, p. 23), a view that fits comfortably with the professional requirements of clinical placements prior to registration outlined above. Thus there is a close link between learning and context thus “workplace learning and performance are significantly shaped by social, organizational, cultural and other contextual factors” (Hager, 2011, p. 23). To discuss these aspects Hager (2011) draws on the work of others, referring in particular to Lave and Wenger’s (1991) “communities of practice

[and] legitimate peripheral participation” (p. 24) to describe the novices’ learning in and participation in communities of practice. Other authors mentioned include Engeström, whose work is discussed later.

Within the current study a socio-cultural view of workplace learning and supervision is adopted and it frames the research methods employed in the study. A qualitative methodology was used to study the work of clinical teachers and their interactions with students and the clinical workplace in which the students have their placements. The reasons for this choice and the actual methods employed are now expanded upon.

Aims and Methodology

The aims of this study are to critically examine the factors that have an impact on how the clinical teacher is able to perform their role and to propose how an understanding of these factors can aid in the professional development of a highly accomplished clinical teacher in nursing education.

Three questions

1. What are the complexities of the practice of the clinical teacher?
2. What are the skills, knowledge and attributes of an accomplished clinical teacher?
3. How can an understanding of the skills, knowledge and practice of clinical teaching be used in the professional development of clinical teachers?

The first two questions concern the first part of the aim of this study as they will identify the skills, knowledge and attributes of the clinical teacher along with the complexities of the role. The data will build upon and expand what is already known to confirm and clarify the current understanding of how Australian clinical teachers perform in their role. The answer to the third question is derived in this thesis through this understanding being used in helping to formulate the content of a set of professional development sessions in a series of workshops run by a School of Nursing and Midwifery for the clinical teachers employed for the clinical placements of students. The data from an initial set of interviews along with reflection on previous workshops

and issues identified within the school the study was conducted in gave the topics for these professional development sessions in the workshops, as will be discussed later.

To achieve the aim and answer the questions a qualitative study is the methodology employed utilising a case study. This study will contribute to nursing's knowledge in that it will expand on nurses' understanding of the role, knowledge and attributes of clinical teachers. The study will also add to their professional development by suggesting ways which can help them move from a novice to an expert in the role.

It is important that full and effective use is made of the clinical practicum for students as the length of time students spend in the clinical field is reducing (Beattie, 1998). There is greater competition for clinical practice places due to the increasing number of nursing students being educated (Courtney-Pratt, et al., 2012). Various strategies are being put in place to address this issue such as increased use of laboratory simulation to increase students' skills prior to the practicum. It is envisaged that this strategy will reduce the need for students to learn basic nursing skills on the practicum and thus make more effective use of the various clinical areas and time on offer in student practicums. The focus of the literature has generally not been on improving the skills of the clinical teacher so that they are more effective in their teaching of students.

Professional practice disciplines use practicums in preparing their students for practice and the literature from these sources also show a lack of research regarding the development of mentors/supervisors/teachers of these students (Bennett, 2003; Higgs & McAllister, 2005; Kilminster & Jolly, 2000). The findings from this study may be transferable to these areas and aid in the preparation of practicum teachers in other fields. There are wider implications for this research as there is a growing trend in higher education for workplace learning (Victoria University, 2007; Walsh, 2006). Students will require support in such programs and a well-designed support and preparation program for the workplace teachers could be adapted from this research for use in many of these.

Role of the researcher

At various times prior to commencing this study I have held clinical teaching positions which provided insights the complexities of the role and the skills needed to be proficient in the role. At the time of the commencement of the study, my position

included planning and running clinical teacher workshops. This provided the opportunity to think more deeply about the role and development of clinical teachers and to make use of these workshops as part of a research program. Over the course of the research for this study I was a clinical unit of study coordinator, a role that included interactions with clinical teachers. This strengthened a desire to develop my knowledge of clinical teachers and the way they work.

Structure of the thesis

The structure of this thesis will follow conventional lines. Following this introduction will be a review of the literature. Clinical supervision of students is, and has been, problematic for a long period. This chapter will explore this history in depth to show why this has been and what has been done about it in the past. Evaluation, or assessment, in clinical placements has been identified as a problem both from the process and practice as well as the consequences of problems, in particular the ongoing problem of the 'failure to fail' students who are not performing adequately. Arguments will be presented regarding some of the reasons why this should be, for example the clinical teacher concept of what nursing is. The concept of novice to expert is often referred to in the thesis and this will be described in relation to clinical teachers. Education concepts are referred to which include pedagogical content knowledge and the objective and subjective nature of assessment practices. Engeström's (1999) concept of knotworking is also discussed as it will be used later to help understand some aspect of the clinical teachers work.

A methodology and methods chapter will follow. In this chapter an argument is presented to justify the use of a generic qualitative research. The argument is based on a view that the commonly discussed qualitative research methods were not seen as being appropriate due to the nature of the research. This approach is supported by the literature where the term "a generic approach" is used and seen as valid qualitative research as long as appropriate criteria are followed (Caelli, Ray, & Mill. 2003). These terms, as well as how these fit the study, are expanded upon in this chapter. So that the reader has a clear understanding of the data collected the four sources are described along with the methods of data collection used, that is, individual and focus group interviews, participant observation notes and document collection. The process of data analysis is described with information on triangulation and theorising as it relates to this

study. Ethical aspects are also presented as these could have proved problematic with this research study.

The next chapter is titled Findings: Perceptions and practices of clinical teachers and clinical teaching. In this chapter findings from each of the participant groups using the different sources of data will be presented and discussed. Over the course of the research changes occurred in both the research site and the position held by the research which had an effect on the data that could be collected. This is reported at the start of the chapter so that the reader has an understanding of the context of the material presented and the changes that occurred. In some cases, for example, recurring themes in the clinical teacher workshops are specifically noted. In other cases the identification of concepts are reported, for example the type and amount of feedback given in the written clinical assessment documents that lead to a particular line of questioning in the interviews and focus groups and which then forms an ongoing point throughout the rest of the thesis. Within this chapter no attempt was made to carry out any theorising or comparison across the data sources, which were left for the following chapter.

The key chapter of the thesis is called “The complex roles of a clinical teacher and a model of developing expertise.” In this chapter the data reported in the previous chapter is synthesised to answer the research questions. It is argued that there are three key roles for a clinical teacher; these are facilitative role, the educative role and finally the assessment role. It is recognised that there is overlap in some cases between these roles but it is argued that it is necessary to understand the aim of the action to understand where it fits in the role. There is also a need to recognise that unless there is an understanding of the roles then there could be difficulties in helping develop clinical teachers. Further a concept of the development of a clinical teacher, from that of a novice to being an expert is developed. Some of the literature is also commented upon in relation to the need of clinical educators in other countries and within the Australian TAFE sector to have undergone specific preparation programs.

The final chapter, “Conclusions and recommendations for the development of clinical teachers” contains recommendations for further action in relation to clinical teachers’ work and development. A critique of the methodology is made. Factors that limit the study are related to the low number of participants and the fact they only came from one institution. The changes that occurred over the course of the study are also factors that

will have affected the consistency of the data. Areas for further research have been identified, in particular the relationship between the clinical venue staff and clinical teachers and the feedback from the venue staff to the clinical teacher about student performance.

It is now appropriate to move on to a review of the literature relevant to the work in this thesis.

Chapter 2:

The work and preparation of clinical teachers: A review of the literature

Introduction

To set the scene for this thesis and the research study a literature review was undertaken to identify what had already been written on the topic. This served as both a starting point and to inform the work and analysis of the findings for the research study. In addition the review looked at a range of literature that addressed aspects not directly related to the work of clinical teachers but which contributes to the research for this study.

This research explores the roles of clinical educators in the education of undergraduate nurses. Consideration of other models to prepare nurse educators, other ways of supporting the student, through for example, mentorship, and preceptorship have been discussed. An international perspective was gained through reviewing literature from the United Kingdom and America, Canada, Australia and others. A key aspect of the literature was utilisation of the work of Benner (1984, 2004) in relation to the novice to expert journey through professional development. Engstrom et al.'s knotworking (1999) provided a key concept for analysing the situation in which clinical teachers find they are operating.

Major themes to come from the search were the preparation, support and development of clinical teachers, the roles of clinical teachers which varied in some cases by the practicum system used in various countries, the attributes and quality of clinical teachers and teaching and a cluster of work around the issue of 'failure to fail' students on clinical practicums.

CINAHL and Academic Search Premier were the main electronic databases searched and produced the majority of sources. ERIC, Emerald and PsycINFO were other electronic databases searched, however these produced limited new findings. Works identified through the reference lists were also followed up if they appeared to be relevant to the study. An initial search was made at the commencement of the study and

then was updated at various points during the course of the study. Search terms used were generally a combination of the following words: clinical, placement, practicum, teach, teacher, education, workshop, preparation, student, and experience. Use was made of the * character to include expanded terms (in particular to add 's', 'er' or 'ing'). As some of these terms are used by other disciplines and areas the search was limited at times by the use of 'nurs*' or 'health' find those relating to nursing or the health field. Most of the searching was limited to the health care field including medical and allied health disciplines and education. The other limit put on findings was to works from post the year 2000 except where original works needed to be accessed to give relevance to more modern works. The year 2000 was chosen to relate to current practice with literature after 2005 of particular relevance.

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Background

Within nursing, as with other practice disciplines, students spend a period of time in the clinical setting, often called practicums, supported by qualified staff to learn the practical aspects of the discipline. This is the case with all health professionals as well as other professions, such as teachers. Within nursing there are various models used to supervise students while they are on the practicum. Some practicums make use of a preceptor/mentor model of supervision while others use a clinical educator model. The clinical educator model can also have variations, clinical educators are provided by the clinical setting to supervise students, or the clinical educators are employed by the university and are placed in the clinical setting with a group of students. In some cases their role is to support preceptors as found in England. The clinical educators employed by the university are usually called a clinical teacher within Australia. It is this last role that is the focus of this literature review and study.

The complexities of working as a clinical teacher may make it difficult to conduct research in the area as these complexities make it quite different from that of assessing

the theory content of the students' nursing course thus making it a multi-factorial endeavour. These complexities are described by Walsh and Seldomridge (2005) when they comment that "Evaluation in a clinical setting is far more difficult because student performance is not simply a measure of ability to perform psychomotor skills. It is also a measure of knowledge, preparation, judgment, and ability to respond to a changing environment" (p. 162).

Over a long period there have been issues with understanding the work of clinical teacher. In 2001 Scanlan commented that "Clinical teaching in nursing is a complex phenomenon that lacks a coherent theoretical base and is perplexing to novices" (2001p. 240). Almost ten years later this thought is still being echoed as in this comment; "Little is known about the skill and knowledge acquisition of nurses in the educator role" (Ramsburg, 2010 Abstract). New work is being produced on clinical teaching although much of it is focused on particular aspects of the clinical practicum, for example Levett-Jones and Lathlean work on belongingness (2007 and 2009), perhaps partly in response to Tanner's comment that "we have very little research about what factors in the clinical education environment make a real difference in student learning" (2005 p. 151). Even where there is work some of this has been criticised, McNamara for example has made the following comment "Conceptual vagueness, semantic confusion and theoretical ambiguity are considered to have hampered research into the effectiveness of clinical learning support" (2007, p. 613). It is envisaged that this thesis will add to the limited work on the preparation of Clinical Teachers.

Scanlan (2001) interviewed groups of novice and expert clinical teachers to try and understand how they learnt to become clinical teachers. She found that "Often there was no orientation to the nursing education program, and novices had no more than the objectives of the nursing course and a list of the students for whom they were responsible" (Scanlan, 2001, p. 243). For these novices "Clinical teaching was learned primarily "on the job." New teachers floundered through trial and error, learning what worked and what did not in any given situation" (Scanlan, 2001, p. 243).

Novice teachers also were shown to have "a great deal of uncertainty about their teaching practices and were unsure about what to do, how to do it, and whether they were "doing clinical teaching correctly" " (Scanlan, 2001, p. 246). Some techniques used to overcome these problems were that "Novices relied on other clinical teachers as

confidants, role models, and sounding boards” and used “mental processes such as reflection, problem solving, and hypothesizing to consider how the meaning of experiences affected their understanding of effective teaching” (Scanlan, 2001, p. 245). Some sought feedback from various sources, mainly students, but only “occasionally did supervisors provide feedback and then it was only seen as valuable if the supervisor was with the clinical teacher as she worked with students” (Scanlan, 2001, p. 245).

Finn, King and Thorburn (2000) identified several themes in a study with clinical teachers that included a lack of knowledge of the curriculum, a lack of teaching credibility, lack of knowledge of what the students are taught in the University, problems with role definition and problems with assessment. The assessment of quality of teaching, or rather the lack of this aspect is discussed in a later section.

The chapter will explore the literature from both nursing and other fields regarding clinical teaching and supervision of students who are on a practicum placement and begin with information on the various placement models used in nursing clinical education.

Nursing clinical placement models

The nursing literature on students’ clinical placements focuses on the way in which clinical practicums are arranged (Mallik & Aylott, 2005; Mannix, Faga, Beale, & Jackson, 2006). Mallik and Aylott (2005) compare the United Kingdom (UK) system, in particular the local area they work in, with Australian practice. This came about via a funded study tour by the authors which compares the practices in the UK and Australia. In the UK students are paired with mentors who are “experienced nurses ... [and] who have completed a recognised teaching and assessing programme” (Mallik & Aylott, 2005, p. 158). These mentor nurses are supported in various ways and by staff who have various position names, for example Mallik & Aylott refer to "Practice Educators" (2005, p. 158). In Australia the usual practice is to have a clinical teacher who:

... are experienced practitioners and/or academic staff employed on a sessional basis to supervise students in practice on a 1:8 ratio ... [and who] further supports a ‘buddying’ of each of the eight students with a practitioner while in the practice placement (Mallik & Aylott, 2005, p. 154).

In some areas this model is being replaced with a similar method of supervision using clinical educators provided by the clinical agency. Although these clinical educators are likely to have had some training or education in clinical teaching this has to be accepted by the university. In other cases these educators do not attend university clinical teacher workshops and so can miss out on the specific information provided in relation to the units the students are completing in their clinical practicum. Other differences are that in the UK it is the mentor who assesses the student while in Australia it is the Clinical Educator. A further difference is that in the United Kingdom the mentors have to undertake preparation (Nursing & Midwifery Council, 2008) while the Australian Clinical Teachers/Mentors often have little if any preparation. In Australia “although students are sometimes [more often usually] ‘buddied’ with a RN for a shift, there is no formal process of preparation for the ‘buddies’ ” either (Mallik & Aylott, 2005, p. 157). There is also no formal requirement in Australia for the Clinical Teacher of degree students to hold any qualification for the position other than being a registered nurse. In North America most reports in the literature would indicate that the supervision of students is the same as, or very similar, to the process used in Australia.

When reviewing the literature it is important to be mindful that where the term clinical teacher is used it is used differently by various authors. In many cases the term is not defined by the authors and if the reader takes them to be the same this may not be the case. In some cases the terms used are regional and relate to the position, for example the term “link lecturer and ... mentors” from the United Kingdom (Gillespie & McFetridge, 2006, p. 641) and “clinical and/or classroom faculty” from North America (Ewashen & Lane, 2007, p. 255). In some instances a generic term is used, for example “clinical educators” (Hsu, 2006; Wray & McCall, 2009, p. 669).

In the United Kingdom the term mentor has specific meaning as used by the registration body, the Nursing and Midwifery Council, to describe the nurse/s who work with a student in the clinical field with the final assessment being carried out by a “sign off mentor”, a “mentor who has met additional criteria” (Royal College of Nursing, 2007, p. 6). The role of mentor can be accepted as being a person who covers the roles discussed here as “role of the mentor [is] a teacher, supervisor and assessor” (Royal College of Nursing, 2007, p. 5).

Mentors may be supported in their role by other clinical or university staff who can have a variety of names; in their article Dadge and Casey (2009) describe themselves as clinical teachers; however recognise there are other terms used including “Practice facilitator [and] Practice placement co-ordinator” (p. 35). A further term found in the United Kingdom literature is that of the “link lecturer” who have a liaison role while also being available for support and educational matters including audits (Royal College of Nursing, 2007, p. 25).

In Australia the term clinical teacher or clinical educator is commonly used along with that of mentor/preceptor and buddy nurse. Forbes (2010) in her study only uses the term “clinical teacher” to refer to the participants. The same term can be found in the work of other Australian authors (For example, Grealish & Ranse, 2009; Kevin, 2006; McKenna & Wellard, 2009) although it is rarely if ever defined. McKenna and Wellard (2009) are an exception as they outline three types of clinical teachers, “sessional clinical teachers [who] are often employed by universities on a casual basis ...”; “staff members of a host clinical agency who are seconded from their regular clinical duties to supervise students ...” and finally “preceptors” (p. 276).

The term ‘preceptors’ is used by others in their studies (James & Chapman, 2009; Zilembo & Monterosso, 2008) although only McKenna and Wellard (2009) attempt to give any explanation of the role. Drawing on the work of Hunsberger (2000) McKenna and Wellard (2009) describe “preceptors [who] work in a one-to-one relationship with students whilst maintaining clinical nursing workloads” (p. 276), which appears to have the same meaning as a mentor in the UK. A final term, again found in McKenna and Wellard’s (2009) study is that of “buddy” (p. 280). The term is used for the “RNs who would care for them [the student] when the clinical teacher was not available”, and were spoken about in both positive and negative lights by them (McKenna & Wellard, 2009, p. 280). It is evident in the literature that a range of terms is used for the same roles. In this study, and to overcome the lack of clarity about the people responsible for clinical teaching of nursing students the following definitions are given and used.

Table 1

Descriptions of names used in relation to clinical educators

| Term | Definition |
|----------------------------|---|
| Clinical educator | Used in a very general sense to indicate somebody who is involved in the clinical education of a student. It will only be used where there does not seem to be another appropriate word to use to describe the person and/or their role or where a generic approach is needed. |
| Hospital clinical educator | Clinical placement agency employed nurse who works as a clinical teacher for students on placement. The nurse often works for the clinical placement agency within their education department or are clinical nurses seconded to the education department to act in this role while students are present. |
| Clinical teacher | Staff, employed by a university on a contractual and/or sessional basis to work with students who are on clinical placement. |
| Preceptor | A term used for a nurse who works with a student over a period of time. The student will usually work the shifts of the preceptor and the preceptor is the educator and assessor of that student. A preceptor will usually only work with one student at a time. In some cases a group of nurses will act as the preceptor of a student (in particular where these nurses work part time so cannot cover all of the shifts of the student). |
| Buddy nurse | Where the student is working with a clinical teacher the clinical teacher cannot supervise the student for all of the time as they have up to 7 other students to also supervise. In this case the process is that a nurse on each shift is responsible for supervising the student when the clinical teacher is not present; this nurse is called the “buddy” nurse (McKenna & Wellard, 2009). |
| Mentor | Within Australia a mentor is generally usually used for post-graduate students. There is also a view that a mentor should not assess a mentee whereas the term preceptor does have this implied in the term. The term is used in the United Kingdom in relation to student nurses in the same way a preceptor would be used in Australia. |

In direct quotations the terms will not be changed however in some cases I will indicate an understanding of which way the original author is using the term by placing the definition used in this study after the word within [] brackets.

There are also other discussions in the literature around clinical placements. These other aspects will now be discussed as they are relevant to this study.

Mannix et al. (2006), discuss the impact the current practice of clinical experience in Australia has on students' learning. They identify the following problem:

... students are cast as visitors to the clinical area. They do not "belong" to the ward ... They are not in any area long enough for bonding with clinical staff to occur. [and that] Students go to 4-6 different facilities a year, and this means learning time is wasted as students engage in a constant process of orientating themselves to different environments, people and practices.

(Mannix, et al., 2006 p. 5).

Along similar lines, Levett-Jones and Lathlean, in a series of works have discussed "belongingness" as an element in relation to students relationships with clinical venue staff and the positive effect this can have on learning if present (2007 and 2009).

These articles raise the issue of the relationship between the students and ward staff. Other issues identified include the difficulties of the fit between the clinical venue and the student's learning needs especially in "the current climate of continual demand and decreasing sites [which] mean that the luxury of selectivity is not always possible" (Mannix, et al., 2006, p. 5) and the ongoing problems with sessional clinical facilitators discussed in other sections of this chapter.

Several suggestions are made to overcome some of these issues. The first of these is a Clinical Teaching Fellow model where clinical teachers, employed by the University, are placed permanently in the clinical setting and if students are not present, work in the clinical setting to continue developing their skills and also to help "strengthening relationships between the two sectors" (Mannix, et al., 2006, p. 8). The second is the "Home Health Facility Model [which] would see cohorts of students being allocated to a home or base hospital for extended periods, or even for the duration of their undergraduate education if the setting was appropriate" (Mannix, et al., 2006, p. 8).

Other models discussed are the University Hospital Model, along the lines of current medical practice, and the Seamless Transitional Support Model aimed to help student transition from their final year as a student to their graduate year of practice (Mannix, et al., 2006, pp. 9-10).

Physiotherapy has some discussions about the clinical model used to teach students. Stiller et al. (2004) discusses views between a Designated Clinical Educator (DCE) model (similar to the model used in nursing with a clinical educator) and a Shared Responsibility (SR) model (where all staff in a unit share the responsibility to look after all the students). The authors conclude that “overall, respondents preferred the DCE model to the SR model, with the perceived advantages of the DCE model including increased time to devote to clinical education, more consistent supervision and assessment of students, and decreased stress levels for staff” (Stiller, et al., 2004, p. 246). Currens (2003) presents on a “2:1 placement model (where two students are placed together with one supervising clinical educator [mentor/preceptor]” (p. 540). The model can be seen to be “immediately attractive in the light of placement shortages, since twice as many students are accommodated. However [it] raises many questions including whether this ‘doubling up’ places additional stress on clinical educators ...” (Currens, 2003 p. 540). Assessment issues, such as “worries that students would not be seen as individuals” is a concern expressed in the paper with this style of placement (Currens, 2003 p. 550). A positive the author notes is that “Peer learning diminishes a didactic teaching style ... and emphasises the students as self-directed learners, participating as equal partners in the learning process” which is the current direction university learning is heading (Currens, 2003 p. 552).

Actions of the clinical teacher to support the students in the clinical environment

In the literature there is some discussion around actions by the clinical teacher which support the students in the clinical environment. Based on a literature review involving 14 articles dated from 1998 to 2008 the first suggestion is that the provision of a supportive environment for students’ helps their learning in the clinical setting (Tanda & Denham, 2009). Other works support this view, in particular the relationship between the teacher and student, for example this comment from an editorial; “several of the articles in this issue, point to an inescapable conclusion: the relationship between

teacher and student and the quality of their interaction is supremely important in learning outcomes” (Tanner, 2005, p. 151). Further support is found in the work of Lambert and Glacken (2005) who state that “It is well documented that the provision of a supportive clinical environment is fundamental to the enhancement of nurse practice education” (p. 670). An example of this is Levett-Jones and Lathlean’s work on “Belongingness” (2007) where they showed that students learnt better in wards where they felt they belong through actions such as being welcomed at the start of the placement. To help achieve this Tanda and Denham (2009) suggest that “Clearer communication and collaboration between nurse educators, clinical educators, and staff nurses about appropriate clinical activities and use of clinical sites seem imperative” (p. 145).

Another way of building on the students’ clinical experience and enhancing their experience is through the use of debriefing sessions at the end of the clinical day. Tanda and Denham (2009) talk about these, using the American term, commenting that “... postconferences provides ways to aid in the development of critical-thinking and decision-making skills as they reflect on one another’s experiences, evaluate outcomes, consider alternatives, and reflect about ways to avoid difficulties encountered in the future” (p. 146). Such sessions will help answer students’ questions and allow them to reflect on the shift better rather than just leaving with unanswered questions or unclear thoughts. These would be easier to run with clinical teachers as they could gather all their group of students together whereas if the student is only working with a mentor they may not be so effective.

Preparation of clinical teachers

Many authors have identified the preparation of clinical teachers as a problem (Andrews, et al., 2006; Lee, Cholowski, & Williams, 2002; Scanlan, 2001). Lee et al. (2002) identified in the literature that some of the current issues “included unqualified and unprepared clinical educators appointed to teaching roles, ... [and] the use of sessional clinical educators, ...” (p. 413). Some recent attempts have been made to address these issues after it was found that “Newly hired clinical adjuncts [teachers] are often novices not only to the program, but also to nursing education” and that “Clinical objectives, formative and summative evaluation, and individual challenges that occur with students are all new and different encounters for these [clinical teachers]” (West et

al., 2009 p. 307 and p. 306). Solutions that West et al. (2009) describe “include a clinical adjunct workshop, collaboration between hospitals and universities, mentoring, and incorporation of technology” (p. 305).

Preparation of clinical educators would also seem to be a problem with other health groups as others commented that “The lack of adequate preparation of clinical educators is a chronic problem in the health sciences ...” (Higgs & McAllister, 2005, p. 156). It is also a problem within the education field as stated in a report on a comparison between cooperating teachers in schools (the educational equivalent of clinical teachers or preceptors) in Australia and Canada; “One clear contrast with the Canadian study is that teachers [in Australia] have participated in little formal preparation for the role of cooperating teacher” (Mitchell, Clarke, & Nuttall, 2007 p. 17).

Support and development of clinical teachers

An issue found in the literature relates to the lack of support given to clinical teachers. There are two areas that have been identified relevant to this issue, the areas that the clinical teachers feel they need support and development in, and the way this support and development is given. This section finishes with some comments on the lack of research in the area by some of the authors commented on here.

Knowledge needed by clinical teachers

Finn, et al. (2000) ran focus groups in their study. One theme to emerge was “Knowledge of the curriculum” saying that “They [the participants] felt hampered in their teaching because they did not know about the students’ past and future learning” (Finn, et al., 2000, p. 135). Assessment was another theme to emerge. “Many [of the clinical facilitators] felt unsure about whether they were using it correctly and worried about giving students poor marks” (Finn, et al., 2000 p. 137). Linked with this the authors also identified other issues. They found ‘71 per cent ... of respondents ... [did] not feel confident using the Clinical performance Indicator assessment tool ... [and] Half of the respondents were worried about students outcomes if they failed a student ...’ (Finn, et al., 2000 p. 138). In relation to support and debriefing the clinical educators expressing a wish to “meet with other facilitators in order to reduce the isolation they felt and to share thoughts on what makes a good prac [sic] for the students” (Finn, et al., 2000 p. 137). Just as students have debriefing these clinical facilitators felt the need for their own debriefing at the end of clinical placements.

In their conclusion Finn et al. (2000) comment that “it appears that part time clinical facilitators of nursing students are often in a position where they feel isolated from the university” (p. 138). This is an issue that McAllister and Moyle (2006b) are trying to address. In their work they report on the development of “clinical education course to prepare Australian clinical educators for their role in supporting students of nursing” (McAllister & Moyle, 2006a, p. 106). As well as the usual content of “learning theories and clinical educational strategies, the course was particularly designed to build an online “learning community” ” (McAllister & Moyle, 2006a, p. 106). The authors see this as important as “a learning community has potential to change the culture from its present state of fragmentation, to fostering connection between isolated clinical teachers” (McAllister & Moyle, 2006a, p. 107).

Within the course the authors say they “deliberately de-emphasise lecture based material and foreground interactive activities through the use of video vignettes, written scenarios, question posing and guided discussion” (McAllister & Moyle, 2006a, p. 107). The course is made up of on-line work with some face-to-face contact via workshops. The authors describe in detail the web presence using the metaphor of a virtual village “In keeping with the idea of building a close-knit community” (McAllister & Moyle, 2006a, p. 108). They also use the simile of a virtual quilt with members of the community of learners adding to it. Within the course there are six education themes listed in a table, they are:

1. What is my role in a learning community?
2. What is the theory behind clinical education?
3. What are the strategies I can use that will engage novices and allow them to realize their potential as clinicians?
4. How can I assess novices so that they remain motivated to learn and to achieve?
5. How can I develop professionally as a clinical educator?
6. What can I do to enrich the environment to promote learning and development?

(Taken from McAllister & Moyle, 2006a p. 109 Table 2).

Written 'handbooks'

A USA study by Pierangeli (2006) discusses the production of a "Teaching Handbook and Reference Manual for Part-time Clinical Faculty" (p. 183). The reason for producing this manual was to support "nurses who, despite expertise in clinical areas, lacked formal training or experience as educators" (p. 183) that were being employed in Pierangeli's (2006) institution to help with teaching. In part the justification for this manual was supported by a quote from Billings and Hallstead: "orientation is particularly important for part-time faculty members, who have fewer opportunities for contact with the school and faculty colleagues." (Pierangeli, 2006, p. 183). Before commencing its production "experienced part-time clinical faculty" were surveyed as to content:

These data revealed that the part-timers wanted information not only about how to teach students but also how to evaluate their clinical skills. They wanted and needed mentoring by an experienced clinical educator, something that time and personnel constraints made it difficult to provide (Pierangeli, 2006, p. 183).

The paper concentrates on the content of the manual which is both generic and specific to the institution. After its introduction feedback was sought from part and full time staff, the finding being that "New clinical faculty found the resource extremely helpful, and course coordinators noticed a decrease in the number of questions the instructors asked about teaching" (Pierangeli, 2006, p. 185). In a study by Finn, et al. (2000) the author's report that their clinical facilitators were "given literature about the subjects covered ... [but] they felt that this was not particularly helpful as it gave no indication of the depth of student learning" (p. 135) therefore the quality of the material would seem to be important as it should address the information that the recipients need.

Electronic sources

One innovation in this area has come from Central Queensland University where they have produced a CD-Rom for distribution to their "industrial educators [who] require knowledge to undertake the role with confidence and effectiveness" (Reid-Searle & Moxham, 2005, p. 20). Prior to developing this resource the "preparation of preceptors ... had been through the supply of voluminous hard copy resources and conducting of

workshops at the University campuses or hospitals in the metropolitan regions” which meant that regional preceptors had to travel to these locations to receive face-to-face preparation (Reid-Searle & Dwyer, 2005, p. 21). The use of CD-Rom technology was decided on by the authors as “the resources needed to go to them rather than the preceptor coming to the educational centre such as the University” (Reid-Searle & Moxham, 2005, p. 21). The content was based on the printed and workshop material the school had previously used changed to better suit the CD medium and included audio and video content (Reid-Searle & Moxham, 2005, p. 24). To assess the usefulness of the CD-Rom fifty educators were surveyed with a 51% response rate with the result that “the survey data indicated a high level of satisfaction with the teaching resource” (Reid-Searle & Moxham, 2005, p. 26). As each university has its own sets of documents and processes this tool would only be relevant to the one university. The authors also commented that “It should be noted that prior to this point in time, no research had been identified that specifically related to a design of a format to prepare preceptors for their roles” (Reid-Searle & Moxham, 2005, p. 22).

Workshops

A workshop format is reported as being a means to educate clinical teachers and educators; “Preparation of staff is most commonly achieved through workshops” (Henderson, Briggs, Schoonbeek, & Paterson, 2011, p. 199). In a report of the development of a new model of clinical placement Bourgeois, Drayton and Brown (2011) state that:

Once clinical teachers were appointed and closer to the commencement of student placement, they were invited to attend the University Facilitators’ workshop. This session provided information about learning and assessment requirements for students across all teaching units, promoted networking by facilitators and gave an overview of university protocols and changes (p. 115).

This is also found in other countries for example in reporting research from England Andrews et al. (2006) comment that:

... many HEIs [Higher Education Institutions] have begun to recognize the importance of support for mentors. For example

... [one] developed a video, workshop and information pack for mentors ... and ... [another was] offering a series of workshops while implementing the new curriculum ... (p. 867).

The institutions involved also run courses for mentors as it is now a requirement in England that all mentors have completed “an NMC approved mentor preparation programme ...” (Nursing & Midwifery Council, 2008, p. 19).

McVeigh et al.(2009) reports on an updating in the way these workshops for community mentors in the UK were presented including changes to the content. These changes were due to poor attendance as “sometimes ... only one or two people attend[ed]” (p. 36). One of the advantages of holding these workshops is found in “the [NMC] standards ... [which] must include an opportunity to meet other mentors and explore mentorship issue with them ...” (McVeigh, et al., 2009, p. 36). The workshops all seem to have similar content, this example from Bourgeois et al. (2011) is typical; “This session provided information about learning and assessment requirements for students across all teaching units, promoted networking by facilitators and gave an overview of university protocols and changes” (p. 115). Later workshops were also held to introduce new clinical teachers where they “addressed more specific elements of clinical teaching, briefing and debriefing, university facilitating requirements inclusive of assessment, policies and procedures” (Bourgeois, et al., 2011, p. 116). Bourgeois et al.’s work is from Australia however similar content of workshops can be found in the literature of both the United Kingdom (McVeigh, et al., 2009) and the United States of America (West, et al., 2009). This type of content is consistent with other disciplines where students have ‘clinical’ placements, for example in a study of Canadian and Australian cooperating teachers (the equivalent of mentors or clinical teachers) the greatest area of support and advice sought by the Australian cooperating teachers was “Specific advice from university about expectations and/or standards” (Mitchell, et al., 2007, p. 19). The use of workshop for preparation would seem to be useful as, drawing on the work of others, McVeigh et al. (2009) comment that “Research evidence has demonstrated that mentor preparation programmes are associated with improved reliability in assessment of students” (p. 41).

Research trends

Research in the field tends to address specific aspects of clinical practicums. Reid-Searle and Moxham (2005) referred to above, present research on preparation material. On more general lines McAllister and Moyle (2006a) argue that “At present in Australia, very little clinical educational research is undertaken, perhaps because clinical teachers and their knowledge base are not sufficiently valued or developed” (p. 107). Since the mid 2000s research undertaken both in Australia and overseas in the area of clinical teaching and the clinical practicum has varied in popularity. In some cases the work has been focused on a particular aspect of the students’ experience such as Levett-Jones and Lathlean's (2007) work on "Belongingness" or more generally, as in the support needed by 'buddy' nurses by Henderson and Eaton (2012).

Nursing is not alone in identifying the problems posed by clinical supervision. In medicine Kilminster and Jolly (2000) comment “Clinical supervision has a vital role in postgraduate ... [and] undergraduate medical education and yet it is probably the least investigated, discussed and developed aspect of clinical teaching” (p. 827). The authors argue that “Current supervisory practice in medicine has very little empirical or theoretical basis” (Kilminster & Jolly, 2000, p. 827) and that “There is little research into the quality of supervision and its content” (Kilminster & Jolly, 2000, p. 831).

Attributes of clinical teachers

Three articles replicating a study by Knox and Morgan (1985), one from the United States of America, one from Australia, and the final one from Greece (Kotzabassaki et al., 1997; Lee, et al., 2002; Nehring, 1990), all have similar findings. It should be noted though that in the Lee et al. (2002) study “respondents ... were not asked to reflect and rate the ‘worst’ educators they had encountered” (p. 416) whereas the others did. Two studies identified the number of students and clinical teachers involved which were approximately half of the numbers in the original study (about 200 students and 25 teachers) (Kotzabassaki et al., 1997; Lee, et al., 2002), while one did not (Nehring, 1990).

All the studies used the Nursing Clinical Teacher Effectiveness Inventory that was developed by Knox and Morgan (1985) and which contains five subscales, Teaching ability; Interpersonal relationship; Personal traits; Nursing competence and Evaluation

(Nehring, 1990 p. 936). Although there is some variation in the ranking of items both between students and faculty and between the three articles the same items tend to appear within the same groupings over the four clusters.

Kotzabassaki et al. (1997) found that the best clinical teacher was

... a person who enjoys nursing, is self-confident, is a dynamic, energetic person and one who encourages a climate of mutual respect and takes responsibility for her/his own actions. She/he listens attentively, understands students' questions, answers carefully and precisely, while demonstrating clinical skills and judgement, is organized and also accessible to students (p. 820).

Nehring (1990) found that "The 'worst' teachers are not good role models, are not empathic and do not provide support and encouragement" (p. 939). These attributes would be supported by comments made by other authors, for example, "the relationship between teacher and student and the quality of their interaction is supremely important in learning outcomes" (Tanner, 2005, p. 151).

A finding in the Lee et al. (2002) study was that

... inexperienced students may have greater levels of anxiety and as a consequence, value moral support more highly than clinical competence. Conversely, the mature age group valued academic guidance more highly than the younger group of students [and as a consequence] ... clinical educators need to be aware of the advantages of using different teaching strategies adapted to student age and prior experience. (p. 417 & p. 419)

Bennett (2003), from the field of physiotherapy, found these attributes of a good clinical teacher are repeated. In one of the questionnaires used in her study respondents gave a list of qualities/abilities that a good clinical teacher needed. By far the highest (numerically) responses were "Approachability [40]; Enthusiasm [37]; Desire to facilitate learning [14]; Good communicator [37]; Share knowledge with learner [14] and Give honest feedback [9]" (n = 42) (Bennett, 2003, p. 434).

From the medical field Kilminster and Jolly (2000) found that "Supervisors need to be clinically competent and knowledgeable; to have good teaching and interpersonal skills"

(p. 834) as well as listing a set of helpful and ineffective supervisory behaviours (see Table 2). These examples from related fields, for example, medicine and physiotherapy, all identify qualities similar to those advocated in nursing literature.

Table 2
Helpful and ineffective supervisory behaviours

| Helpful supervisory behaviours | Ineffective supervisory behaviours |
|---|---|
| Giving direct guidance on clinical work | Rigidity |
| linking theory and practice | low empathy |
| joint problem solving | failure to offer support |
| offering feedback | failure to follow the supervisees concerns |
| reassurance | not teaching |
| role model[ing] | being indirect and intolerant |
| | emphasising evaluation and negative aspects |

(Adapted from Kilminster & Jolly, 2000, Table 6, p. 834)

Although not necessarily an attribute of clinical teachers, Baxter and Rideout (2006) comment that in their study on clinical decision making students tended to access “the clinical tutor much less often than the nursing staff” and that when they did it was “when they wanted rationale for a nursing action, when they needed emotional support, or when the tutor needed to act as a liaison between the nursing staff and students” (p. 126).

Clinical teachers’ development

The literature has some things to say about the development of clinical teachers that align with the direction of this study. There is an identification of a progression in their development as well as evidence that experts use ‘intuition’ as described by Benner (1984). It takes time for the clinical teacher to develop their own persona as well as to build the relationships they need to function effectively in the role.

Drawing on literature in the field on development stages in teachers and clinical educators Higgs and McAllister (2005) say they “found a similar progression from survival to maturity, and from self-focus to other-focus. These transitions in teachers

took some years” (p. 165) and suggest that their participants went through three stages, “novice, advanced beginner and competent practitioner” (p. 165) citing Dreyfus & Dreyfus and Benner. West et al. (2009) also describe a pathway of clinical teachers moving from novice to expert with comments such as “Schools of nursing must develop enhancement strategies and educational pathways to develop clinical faculty from novice to expert” (p. 306). This transition from novice to expert may not be a rapid process as although they are not talking so much about clinical teachers but lecturers, Heinrich, Hurst, Leigh, Oberleitner, & Poirrier (2009) comment that “It can take between 10 and 15 years for nurse educators to exchange their clinical identity for that of teacher-scholar” (p. 185). The concept of Benner’s novice to expert can also be applied to students as this comment shows; “Perhaps the concept of novice-to-expert needs to be revisited as it suggests ways preceptorship, practice-based clinical instruction, and residency programs can help novice student nurses increase expertise” (Tanda & Denham, 2009, p. 140).

Another way that Benner’s concepts have been referred to in relation to student assessment is that of intuitive understanding through the use of expert knowledge; In a phenomenological investigation using 10 participants from rural areas, a possible limitation to the study, Paliadelis and Cruickshank (2003) comment “The major finding that emerged from this study was that expert knowledge is used by a group of rurally based registered nurses to assist them in the student nurse assessment process” (p. 7). The authors continue that this is “consistent with a substantive amount of literature which indicates that intuitive knowledge is used when judging competence and safe practice” (Paliadelis & Cruickshank, 2003, p. 7). It is appropriate to use the term intuitive as the quotes from the respondents in this work talk of “You just kinda know”, “have a gut feeling” and “nursing is very much an intuitive ... an intuitive science” (Paliadelis & Cruickshank, 2003, p. 6). This may be one reason why, as will be discussed later in more depth, that nurses who assess students are not good at documenting issues with them, the difficulty with being able to document these ‘gut feelings’.

Ramage (2004) found that the link lecturers in her study, which involved 28 in-depth interviews over a period of 7 years, had to negotiate multiple roles to build a new identity for themselves in taking on the role. It was found that the participants

developed a “complex interplay between self and others in ‘building up the goodwill’ and ‘trading relationships’ ...” and that in “endeavouring to gain the acceptance of nursing staff led to a neglect of students’ learning needs” (Ramage, 2004, p. 293). Ramage (2004) ends by saying “This research indicates that novice teachers will need educating about concepts such as change management and the influence of social groups on role development” (pp. 294-295). Ramage supported the comments by Higgs and McAllister (2005) about the length of time it takes for educators to develop their educational role, saying that “it took lecturer practitioners 4 years and link teachers 7 years to establish their educational persona in clinical practice” (Ramage, 2004, p. 293)

Nursing students’ views

Nursing students have been respondents in research studies or sources of information in relation to clinical teachers and teaching. It should be noted that in some cases the students used in the studies may come from a narrow group, one year of a course, while in other cases it may be a whole course or over several years of a course.

Kelly (2007) reports on studies undertaken in 1989 and 2003 where the same group of questions were asked of 30 students each year undertaking a three year diploma in the earlier study and a four-year baccalaureate degree in the later study along with other differences in the curriculum which would make comparison between years difficult. The difference in courses was due to a change in the level of the course taught at the institution over the time period between the studies. Three questions were asked of the students:

1. Tell me about the most effective clinical teacher you have had to date (no names please). I need a detailed description of what made that teacher effective for you.
2. What three qualities do you believe are most important for teaching effectively in clinical settings? Please rank orders those.
3. In addition to what you have shared with me so far, is there anything else that influences (enhances or detracts from) your learning in the clinical area?

(Kelly, 2007, pp. 887-888)

Four main themes emerged from this study, knowledge, feedback, communication skills and environmental factors (Kelly, 2007, Table 2, p. 888). These tend to focus on the attributes of the clinical teachers rather than indicating what they see are the roles of the clinical teacher although it can be inferred from the results that the clinical teacher needs to have content (that is nursing) knowledge, be able to communicate well so as to give feedback and to have an awareness of the clinical environment. To support these roles Forbes (2010), in a recent work and drawing on others, gives the following examples of the activities of a clinical teacher; “In particular, teachers help students to make the links between theory and practice ... negotiates learning experiences ... provides guidance ... and diagnoses learning problems [and later] ... Evaluation of performance” (pp. 785-786).

Problems for students have been identified as well as the coping strategies they may use. “Clinical practice is fundamental to the nursing students’ learning, however, many experience problems and difficulties during their clinical practicum” (Chapman & Orb, 2000, Introduction, para. 2). Students would often go on placements with mixed feelings, for example; “While on some occasions [the students] discussed feeling scared, nervous, stressed, intimidated, and awkward. On other occasion’s students found clinical practice to be exciting, interesting, important and enjoyable” (Chapman & Orb, 2000, Findings, para. 4). Other findings reported in Chapman and Ord’s (2000) article was that “the relationship that students had with their clinical teachers ... was fundamental in the process of their learning. [and] participants considered that teachers’ [sic] positive attitudes enhanced their learning” (Findings, para. 8).

Chapman and Ord (2001) reported on coping strategies students used with their clinical placements. Three strategies involved clinical teachers. “Participants found ‘talking things over’ with their ... clinical tutors to be helpful” among other people in their lives as one strategy that they used to relieve anxiety (Chapman & Orb, 2001, p. 98). The second was the use of a student grapevine where “Details such as the idiosyncrasies of the clinical tutor ... were shared within the student body” (Chapman & Orb, 2001, p. 99). Care plans were also reported to be a “source of stress and anxiety for the students” and these were also shared in this way but the grapevine could also have negative effects and poor reports of a teacher or venue could increase the anxiety for some students prior to their placement (Chapman & Orb, 2001, p. 99). The final strategy was

called "... 'play the game' – in other words, becoming what or whomever the nursing staff and clinical teacher wanted them to be" (Chapman & Orb, 2001, p. 99). An important part of this was "knowing what ... their clinical teacher expected of them"; two ways were used to find this out, either observing the clinical teacher interacting with other students or by directly asking the clinical teacher what these were (Chapman & Orb, 2001, p. 100).

Andrews et al.'s (2006) work comes from England where mentorship is the method used to supervise students on clinical practice. This method of supervision is not without its problems as the students in this study "commented that their mentors were often unprepared for, or unaware of, their role" (Andrews, et al., 2006, p. 866). This is perhaps surprising given that all nurses who mentor students in the UK are expected to have undertaken an approved course in mentoring (Nursing & Midwifery Council, 2008). Andrews et al. (2006) also report that "it was noticeable in the data that students did not either undertake, or expect to undertake, active learning" with "Much of the data collected highlight[ing] student[s] expectation of passive learning, being taught by others ... rather than actively seeking knowledge and skills themselves" (p. 869).

Gillespie's (2002) Canadian work using 8 interviews and a follow-up focus group of 6 of these participants looked at student-teacher connection, an important issue given other findings that the students' relationship with their clinical teacher is important to their learning. In talking about the positive aspects Gillespie (2002) reports that:

... it was evident that the egalitarian nature of the relationship arose from an equality as people and, notably, that this personal equality coexists with an inequality of knowledge and skills, or a functional inequality. ... In sharp contrast with the fearfulness and anxiety that often characterized their nonconnected student-teacher relationships, all students described feeling 'at ease' in connected relationships. (p. 569)

and

Connected teachers were differentiated from nonconnected teachers by their ability to teach 'more than the technical aspects of nursing', and to support students in developing process skills

such as clinical judgement, organization and communication and, consequently, developing as a nurse. (p. 570)

Some reasons for this non-connectiveness are given. Students in the study “suggested that teachers created distance between themselves and students when they lacked confidence, thus inhibiting knowing and connection” and also “When they used their more extensive knowledge base to emphasize the difference in roles and status of the students and teacher, students invariably described a lack of connection” (Gillespie, 2002, p. 571). This latter factor may also possibly be related to a lack of confidence as the clinical teacher may fall back to where they are comfortable, their area of expertise, when they feel uncomfortable.

The overall effect of connection/non-connection has been summed up in the following statements.

The connected teacher was present as a coach and guide. In this role, compassion, exemplified by an authentic, accepting and patient presence, came together with their knowledge, abilities and skills as educator and nurse. From this basis connected teachers supported learning ...’ while the non-connected teacher was seen ‘primarily as an evaluator, a perception reinforced by the non-connected teacher’s tendency to ‘grill’ them with questions, offer only ‘negative’ [sic] feedback, to ‘constantly critique’, and ‘watch them like a hawk’ (Gillespie, 2002, p. 572).

Gillespie (2002) concludes that “in connected student-teacher relationships, students described being able to ‘focus on learning’ ” while “In contrast, their focus in a nonconnected relationship was on ‘getting it right’ and ‘pleasing the teacher’ ” (p. 573).

Jackson and Mannix’s (2001) work is not related to clinical teachers but to clinical staff who also support and teach students. It does, however, have some useful information on students’ views about clinical placement. Jackson and Mannix (2001) also report that students in their study found the experience stressful; “They described feeling filled with anxious anticipation. The students desperately wanted to perform well ...” (p. 273). Again, reflecting other research, it was found that “The most common helpful

behaviours identified by the respondents were understanding and being friendly” (Jackson & Mannix, 2001, p. 273). Commenting on clinical staff “students described instances where they felt excluded, ignored and even disliked by some nurses in the clinical areas. ... [and there was a] perception that nurses were not willing to share information and contribute to students learning” (Jackson & Mannix, 2001, p. 275).

Recent work reporting on “Clinical Teachers’ Conceptions of Nursing”, part of a PhD study, (Forbes, 2011) found that there were four ways nursing was conceptualised by the clinical teachers (See Table 3) and which could be seen to be hierarchal. There may be implications in how clinical teachers, and possibly clinical staff who work with students, rate and assess students based on their conception of nursing. For example if the clinical teachers approach is A or B (See Table 3) then completing the work on time and accurately would be sufficient for the student to pass, with a high grade if the placement is graded. However if the approach falls more to C or D (See Table 3) then more work has to be done by the student, in particular in the communication and using more nursing knowledge to formulate appropriate care to gain that higher grading or to pass the unit. Forbes in a different article calls the first two approaches ‘nurs[ing] focused’ and the latter two a ‘patient-focused approach to nursing’ (Forbes, 2010, p. 791).

Table 3
Clinical teachers’ conceptions of nursing.

Conception A: Nursing is performing tasks.

Conception B: Nursing is more than performing tasks; it is providing appropriate patient care required at the time.

Conception C: Nursing is providing appropriate patient care aimed at achieving individual patient outcomes.

Conception D: Nursing is collaborating to provide appropriate patient care aimed at achieving individual patient outcomes.

(Forbes, 2011, p. 155)

Problems identified related to clinical teaching

The literature has identified two major problems with the actions of clinical educators; these are the failure to fail poor performing students and that of grade creep. Although this latter issue is not confined to clinical teachers and clinical grades, more recent literature has indicated that it is more extensive when clinical units are compared to theory units. These two issues are discussed below.

Failure to fail

A major issue identified in the literature that causes concern is what is seen as the failure to fail students, or at least until the very last practicum in a course, by clinical teachers and is an ongoing issue for nursing. Almost all of this literature comes from the United Kingdom (Brown, Douglas, Garrity, & Kim Shepherd, 2012; Duffy, 2003; Fitzgerald, Gibson, & Gunn, 2010; Jervis & Tilki, 2011; Rutkowski, 2007; Sharples & Kelly, 2007) with some from Canada (Brown, Neudorf, Poitras, & Rodger, 2007; Luhanga, Yonge, & Myrick, 2008a, 2008b) however there is no reason to suppose this is not a problem within Australia; hence its discussion here.

Historically this is not a new issue as seen in these comments by Lankshear (1993) who commented as early as 1993 that “many students who should have failed practical assessments were given pass grades” and continued “The reasons given for the 'failure to fail' were various ... (Lankshear 1990)” (p. 1988). The following table (Table 4) attempts to set out the common reasons given by various authors and indicates that there are some consistent and ongoing issues in relation to this failure to fail students. The table is set out to show Duffy's earlier work that comes from a PhD scholarship funded study, which is taken as the starting point for this discussion, and finishes with the most recent work found on the topic. The middle two columns show English and Canadian works to indicate that over an eight year period, and in different countries, the issues are unchanged. The order in which they are discussed does not imply either a hierarchy or order of importance.

Table 4**Reasons for failure to fail students**

| Initial work (Duffy, 2003) | Other English authors (Fitzgerald, et al., 2010; Rutkowski, 2007; Sharples & Kelly, 2007) | Canadian works (Luhanga, et al., 2008a, 2008b) (Brown, et al., 2007) | Most recent work (Jervis & Tilki, 2011) |
|---|---|---|--|
| Leaving it too late (in the unit) | Reluctance to document students actual | Feelings of guilt or self doubt | Complexity of assessing students |
| Failure left to later in the course | achievement/issues with students | Insufficient time to work with students | Stress of the decision |
| Personal consequences (to the student) | 'Inconsistencies between feedback given to | Unsupported by faculty (the university) | Reluctant to fail students early in their |
| Social stress the student is under | students and feedback given to the university' | Lack of experience as a preceptor, | training |
| Difficult for a member of a caring | More assertive and aggressive students | Reluctance to cause students to incur personal | "They will improve" |
| professional to fail somebody | Mentors with poor understanding of student | cost, | Worry about the consequences of failing a |
| Feel they have failed to support the student | learning outcomes | Personal feelings of guilt or shame, | student |
| Willing to give 'benefit of the doubt' | Poor documentation of student issues | Complacency or reluctance to assume the | Negative criticism from students and the |
| Lack of time | Not understanding the assessment forms | extra workload, | university |
| Lack of experience | Insufficient time to work with students | Lack of appropriate evaluation tools and time | Pressure from the university to pass a student |
| Lack of support | Patient care prioritised over assessment | to evaluate sufficiently, and | Difficulty in assessing attitudes |
| Pressure from students to pass | Poorly prepared mentors | Pressure of the perceived nursing shortage for | Mature students who were assertive |
| 'Not bad enough to fail' | Fear a fail mark means the mentor was not | preceptors to create graduates | Good clinical skills but poor interpersonal |
| Unclear definitions of 'unsafe practice | able to provide a suitable learning | Personal cost to the student | skills tend to pass |
| Difficult to fail a student with an 'attitude | environment | Close student-preceptor relationship | Trying hard was often rewarded with a pass |
| problem | Fear a fail would be overruled on appeal | Difficult to fail on a poor attitude/affective | Lack of confidence in their own ability |
| Problems with assessment documents | Placement did not match students needs | domain | Unclear documentation especially related to |
| Student given the 'benefit of the doubt' | (specialist placement) | Inappropriate evaluation tool | attitudes |
| Non-documentation of issues | Personality mismatch between student and | | Could not prove concerns were valid |
| | mentor | | Given the 'benefit of the doubt' |

The first issue discussed is the theme identified by all researchers and that is problems with the assessment documents. These range from just general comments in relation to the documentation being an issue through to the comment that these were inappropriate (Brown, et al., 2007; Luhanga, et al., 2008a). In the work by Rutkowski (2007) it was identified that the assessors did not understand assessment forms while in the work of Jervis and Tilki (2011) the participants felt that the documents were unclear in the assessment of attitudes. Linked to this last comment, were issues around the difficulty about failing students in relation to attitude problems. This is something that has been identified in other literature as a problem area for clinical educators (Miller, 2010). Another issue identified is a growing trend for students to be more assertive, in particular among mature students which in some cases is leading to a degree of aggressiveness in students in general (Fitzgerald, et al., 2010; Jervis & Tilki, 2011). The implication here is that it puts pressure on the clinical educator to pass the student even though they may have some doubts about whether the student has reached the standard required or not.

The time needed to assess students was also identified. The way this was expressed varied, in Duffy's (2011) work just as a lack of time while Jervis and Tilki (2011) identified that patient care took priority over assessment for some participants. This was mirrored in the work by Luhanga et al. (2008a) where a lack of time to evaluate sufficiently was identified as an issue as well as a reluctance to take on the extra workload involved. This is particularly an issue with students being placed with mentors and should not be such an issue with clinical teachers as they do not have a patient care load although Susmarini and Sri Hayati (2011) from Indonesia highlight the problems with the time the clinical assessors can spend with students to evaluate them, giving an example where an educator in their study reported that they can only "spend 15 to 20 minutes per student each week" (p. 24).

A further issue is that of 'personal consequences' (Fitzgerald, et al., 2010) to both the student and the educator. For the student this relates to the personal cost for them of failing and the implications of this for their progression and them personally. This is a major issue and may well be the reason why Fitzgerald et al. (2010) comment that "There appeared to be reluctance on the part of the mentors to highlight difficulties/issues with students directly who were not performing as expected" (p. 161).

Also of concern, and something that may well be an indication that clinical educators are not well prepared are comments about how the educators feel themselves. These “personal feelings of guilt or shame” on the part of the educator (Luhanga, et al., 2008a, p. 6) stem from a feeling that they did not give sufficient support to the student (Duffy, 2003) or provide a suitable learning environment (Rutkowski, 2007) or was related to the stress of making the decision to fail (Jervis & Tilki, 2011).

Grade inflation

Grade inflation is a term used where student grades are higher in some units than others. In nursing this mainly happens in clinical units as the following two graphics (

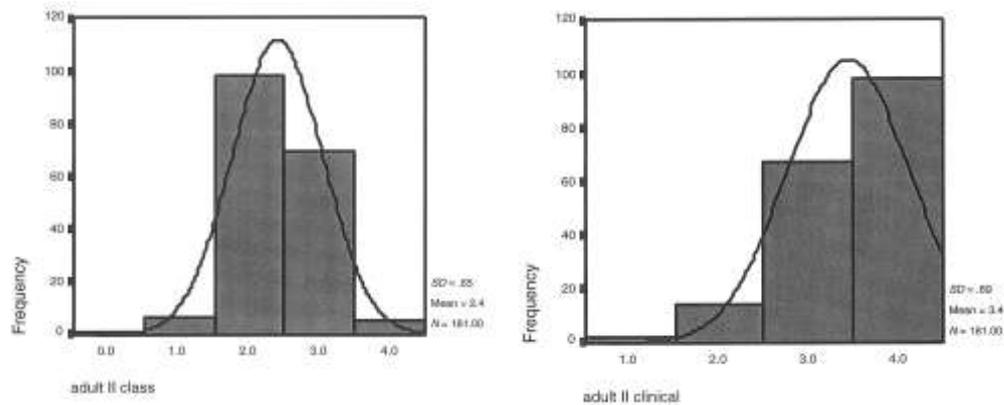


Figure 1) show. They represent the grades given to two sets of students in a linked theory and clinical unit in the same institution (Walsh & Seldomridge, 2005) with the theory unit grades on the left presenting the more usual ‘bell curve’ in results while the clinical unit on the right shows a shift in grades to the right, or high scores. This is not a new phenomenon in both academia and the health care field.

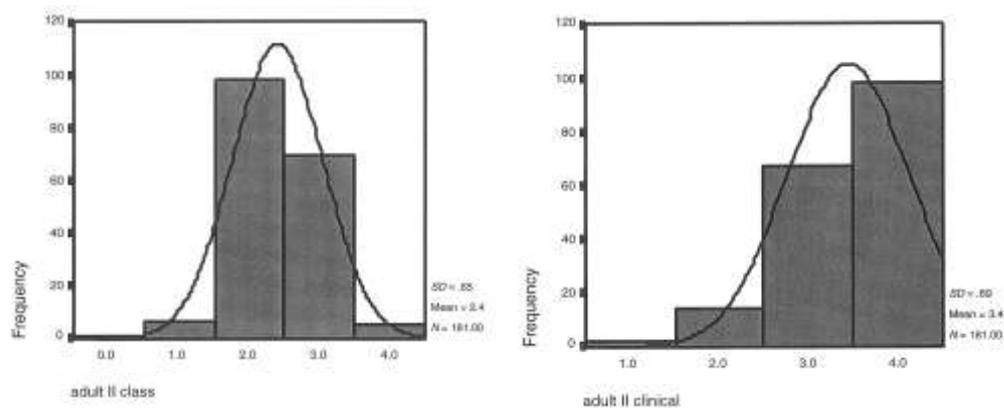


Figure 1
Comparison between Theory and Clinical grades

(Note ‘adult II class’ on left is a theory unit while ‘adult II clinical on right is a clinical unit. (Walsh & Seldomridge, 2005, p. 165))

Scanlan and Care (2008) have discussed this issue and arrive at a consensus that it is an issue that should be addressed. The major reason for the need to address the issue is found in this comment “inflated grades in clinical practice give students an unrealistic and inflated perspective regarding their ability to safely practice nursing” (Scanlan & Care, 2008, p. 185) making students think they have better abilities than they really have. In their work Scanlan and Care (2008) say that:

There are a number of reasons for grading discrepancies leading to clinical grade inflation:

1. The subjective nature of clinical evaluation
2. The high turnover of clinical faculty, which results in more novice evaluators
3. Poorly constructed, nondiscriminating clinical evaluation instruments
4. Clinical instructors who are reluctant to grade down for actions not seen and err on the side of leniency
5. The difficulty of applying professional practice standards to criteria for clinical evaluation
6. The students' relationships with buddy nurses who also serve as evaluators (p. 178).

All of these are issues that are either identified in this chapter as issues for clinical teachers in relation to assessing students or were found in the study and discussed as issues. The authors reported that this issue was tackled in various ways including discussions about grades and grading in the workshops for preceptors (Scanlan & Care, 2008).

Assessment of quality

There is limited literature in the area of the assessment of quality of clinical teachers and clinical teaching. There is evidence that clinical teachers are not prepared or feel poorly prepared for their role and are often novices to the role (Lee, et al., 2002; Scanlan, 2001). There is some information about the ways different institutions are preparing their clinical teachers (Bourgeois, et al., 2011; McAllister & Moyle, 2006a;

Pierangeli, 2006; Reid-Searle & Moxham, 2005) however the effect of this preparation does not appear to be assessed in these or other articles.

There was an earlier discussion on the literature which identified the attributes of clinical teachers (Bennett, 2003; Kotzabassaki, et al., 1997; Lee, et al., 2002; Nehring, 1990). Good attributes could be associated with good quality teaching while poor attributes would be associated with poorer student experiences and learning. Within these articles no recommendations were identified as to how bad practices could be changed into good ones, it seemed to be assumed that if these were identified then clinical teachers would identify with them and so change their practices if needed.

There is a lack of evaluation or assessment of the effectiveness of clinical teaching. Mannix et al. (2006) say that “However, there remains the question of how educational providers evaluate models of clinical teaching and learning” (p. 4) while Mallik and Aylott (2005) say “There is still the need to complete some targeted evaluation studies of the relative effectiveness of both modes of clinical learning on the ‘fitness for practice’ of Australian nursing graduates” (p. 158). This situation has not changed from these papers yet if clinical teaching is not evaluated how can the quality of the clinical teaching be judged? It should be acknowledged that there may well be local assessments of teaching and venues however these are generally not reported in the literature.

The views of students who are the recipients of teaching in the clinical field, actually written by students, were lacking. The few views presented from this aspect were produced by academics, not students themselves. It would seem to be important to seek students’ views as they are the ones most affected by clinical teaching and without this only a one sided view is obtained. A lack of student written papers is in keeping with the nursing literature in general, where very few papers are noted to have been written by undergraduate students, even where the author/s identify themselves as students it is usually in relation to post-graduate studies, not undergraduate.

Novice to expert

In nursing Patricia Benner’s name is synonymous with the concept of novice to expert however the original work was carried out by two brothers Hubert and Stuart Dreyfus and “was used by Benner as a framework for analysing her research data” (Gardner,

2012, p. 339). Dreyfus's original work was about computers and making them think like humans using rules however they reported in a later work that using:

... phenomenological description ... a beginner calculates using rules and facts just like a heuristically programmed computer, but that with talent and a great deal of involved experience, the beginner develops into an expert who intuitively sees what to do without recourse to rules (Dreyfus, 2004, p. 180)

Note in this quote two significant comments, the first is the beginner uses rules and facts in a way that a computer program does, it sorts through factors one at a time to arrive at an answer, while the second is the expert needs 'involved experience' before they become one. This supports the notion that it does take time to become an expert identified earlier in this chapter.

Benner (2004) discusses five stages a person moves through, these are the Novice, Advanced beginner, Competent, Proficient and finally arriving at Expert. Benner (2004) sees a degree of a time line in this, she calls a novice as being "First year of education", and advanced beginner as being a "New Graduate" with competent as being up "to 2 Years in Practice" (pp. 191-193). Benner does not give any time stages for the last two levels though. There is no particular 'time' for a person to go through a stage, they can even go back to a lower level in some situations, "a nurse may return to the novice stage a number of times in their career or remain at the stage of novice for many years" depending on their situation (Lyneham, Parkinson, & Denholm, 2009, p. 2480). This can be found in the case of expert clinicians who move into becoming clinical educators where they are novices in their new role.

Thus to develop expert skills, in whatever area a person is working in they need to spend time working in that area. There is also the recognition that this can take time and occurs with the passage of time rather than in one short hop, it "is the result of practicing these skills in everyday interactions" (Janzen, 2010, p. 521). It is not just a matter of knowing as Benner in her original work "clearly established in nursing that, without experience, knowledge had little impact on practice development" (Lyneham, et al., 2009, p. 2480). It is not possible to present all the various variegations they may come across within books or other educational methods to clinical teachers as:

The range and variegations cannot be captured fully in textbook, a problem known in philosophy as *the limits of formalism* [original emphasis]. Also, the perceptual skills associated with recognizing fuzzy or family resemblances, qualitative distinctions, and real-life presentations complete with their range of manifestations cannot be captured in two-dimensional textbooks or single case presentations (Benner, 2004, pp. 192-193).

The above may, to some, suggest that it is not possible to teach the required skills to a person. It is rather the case that knowledge is needed, through education sessions, so that different skills are known about and can be used in practice as Janzen suggested above. Benner (2004) recognises this view where she commented that “Because practice in the individual case is underdetermined (i.e., open to variations not accounted for by science), the practitioner must use good ... reasoning to intelligently select and use the relevant ... [interventions]” (p. 189). Thus for a person to select and use any intervention they must have a range of interventions to choose from that they have already learnt. Both development and experience is needed to develop into an expert.

Dreyfus (2004) uses the term “intuitive” to describe some of the actions or decision making of the expert. Field (2004) makes the following comment; “Possibly Spouse’s (2001) mentor was using her craft knowledge so instinctively that she was no longer able to elucidate the steps leading to her decision making” (p. 561) to illustrate this point. Another term that is used is tacit knowledge, which Altmann (2007) says “is something we just know or do because we have had multiple exposures or experience” of (p. 117). This view is not without its critiques, Gardner (2012), drawing on the work of Schön is one, who believes that it is possible to bridge the gap between theory and the practical knowledge of practitioners, thus being able to “articulate it and pass it on to students and colleagues” (p. 240). There are two issues with this discussion. The first is that based on Gardner’s view of Schön’s work it is worth while having expert teachers articulate the processes they use to novice teachers. The second is where clinical teachers say they are unable to articulate why they feel a student should fail or to be able to put these reasons in writing should not be accepted as it should be possible for them to tease out the reasons.

Pedagogical content knowledge

Many nurse clinical teachers have little if any preparation for their position. They are often experienced clinical nurses who have shown an aptitude and/or interest for teaching but have received little if any formal education on teaching. The following quote sums up the situation regarding clinical teaching in the health care field; “There is a tacit assumption that expertise in practice will translate into proficiency in teaching” (McLeod, Steinert, Meagher, & McLeod, 2003, p. 638). In the mid 1980’s Shulman wrote about the skills needed by school teachers identifying three forms of knowledge that were needed, and exhibited by skilled teachers, content (subject) knowledge, pedagogical (teaching) knowledge and a middle ground that he called pedagogical content knowledge or PCK (2004a, 2004b).

Veal and MaKinster (1999), referring to the work of Shulman and others say that

These researchers described pedagogical content knowledge as the knowledge formed by the synthesis of three knowledge bases: subject matter knowledge, pedagogical knowledge, and knowledge of context. Pedagogical content knowledge was unique to teachers and separated, for example, a science teacher from a scientist. (Theoretical Framework, para. 1)

They continue

Furthermore, Shulman (1987) stated that PCK included those special attributes a teacher possessed that help him/her guide a student to understand content in a manner that was personally meaningful. (Veal & MaKinster, 1999, Theoretical Framework, para. 4)

Veal and MaKinster (1999) gave an ‘operational definition’ of PCK as:

Pedagogical content knowledge is the ability to translate subject matter to a diverse group of students using multiple strategies and methods of instruction and assessment while understanding the contextual, cultural, and social limitations within the learning environment. (Taxonomy of PCK Attributes, para. 7)

This definition would fit very well with the sorts of environments that clinical teachers have to work in.

Chick, Baker, Pham & Cheng (2006) developed a framework for analysing pedagogical content knowledge or PCK. Within this framework they split PCK into three categories, 'Clearly PCK', 'Content Knowledge in a Pedagogical Context' and 'Pedagogical Knowledge in a Content Context'. The authors say that in the category 'Clearly PCK' "pedagogy and content are completely intertwined" and give examples such as "knowledge of students thinking ... [and] knowledge of a range of alternative models and representations" (Chick, Baker, et al., 2006, pp. 2-298). This form of knowledge and the ability to use it, as is the next, is helpful to a teacher when they have to guide the student's knowledge development. Content Knowledge in a Pedagogical Context is described as including "the ability to deconstruct knowledge to its key components" while Pedagogical Knowledge in a Content Context "covers situations where teaching knowledge is applied to a particular content area" (Chick, Baker, et al., 2006, pp. 2-298).

Chick, Pham & Baker (2006) go on to discuss some specific areas of PCK which were apparent in the explanations given by the teachers in their research. These include the teaching strategies the teachers would use to correct mistakes; knowledge of student thinking, including their conceptual understanding; student thinking – misconceptions, identifying errors in student thinking; explanations, procedural knowledge and methods of solution, or ways that the teachers used to correct misunderstandings; curriculum knowledge, where the item fits in the curriculum; and goals for learning, getting and maintaining student focus, which were ways the teachers would help students to learn (Chick, Pham, et al., 2006, pp. 143-145).

The problem comes if the teacher is not able to do this, in particular where the teacher's role is to assist the student in developing their knowledge. This is supported by Jones and Moreland (2005) where they comment that "Effective formative interactions are then dependent on informed assessors who are able to interpret observations and student outcomes, and consequently act upon the interpretations to enhance student learning" (p. 196). Drawing on work by Black and Wiliam they add "Therefore if teachers have less robust pedagogical content knowledge they are more likely to emphasize the quantity of students' work rather than its quality" (Jones & Moreland, 2005, p. 196).

Within nursing this has already been discussed with the issues of some educators focusing on the tasks or quantity of work rather than interaction, quality, as was presented by Forbes (2010, 2011).

Knotworking and co-configuration

Engeström, Engeström & Vähäaho introduced the concept of ‘knotworking’ based on a “series of recent studies” (1999, p 346). In this work they draw on situations where there can be a constant changing situation, either in personal or work, where the worker “literally construct[s] the collaborative relations on the spot as the task demanded ...” which they called “*knotworking* ... [which] refers to a rapidly pulsating, distributed and partially improvised orchestration of collaborative performance between otherwise loosely connected actors and activity systems” (Engeström, et al., 1999, p. 346 Emphasis added). The situation of clinical teachers fit with the description of knotworking “as participation in a particular kind of system that forms at the confluence of diverse collaborating organisations and discourses” (Fenwick, 2007, p. 140). For clinical teachers the organisations are the clinical venues and the university they work with while the discourses being clinical and theoretical with the students, the clinical venue staff and the supporting academics. This is supported with comments by Lambert and Glacken (2005) where they recognise that “Nevertheless, the clinical learning environment is not without its problems. It can be erratic and energetic with unforeseeable changes, lacking in reliability and identical experiences”, which can be a major challenge to clinical teachers (p. 665).

Communicative actions are seen as important as “In knotworking, the combinations of people and the contents of the tasks change constantly” (Engeström, et al., 1999, p. 353) thus requiring multiple interactions involving communication or repeated communication. Although the students do not change for the clinical teacher over a two or four week period the clinic staff on each ward can vary from one shift to another as well as the patients and their status meaning there are multiple people the clinical teacher has to communicate with. The ever changing environment is further recognised by Engeström et al. (1999) when they comment “knotworking situations are fragile because they rely on fast accomplishment of intersubjective understanding, distributed control and coordinated action between actors who otherwise have relatively little to do

with each other” (p. 352), again this is the sort of situation a clinical teacher often finds themselves in.

Engeström makes no comment about the ability of people to work within this fluid space where knotworking occurs. Others do comment and suggest that “Not all individuals were able to function effectively within this discursive informality and loose interconnections” (Fenwick, 2007, p. 145). Working within the knot requires consent negotiation and re-negotiation, often with a degree of improvisation to achieve an acceptable end. Fenwick (2007) suggests that “Those who thrive in the knots appear to be continually self-reflexive to their own implication and strategies in the unfolding languages, the connections and disconnections, at both micro and macro levels” (p. 151) while other authors suggest that “they develop innovative ways of working in order to accomplish the objective more efficiently or effectively” (Bishop et al., 2009, p. 245). Bishop et al. (2009) drawing on Fenwick’s work comment “that ‘knotworking’ relies on individuals’ possessing skills that allow them to span discursive boundaries and communicate with a wide range of partners” (p. 253) which is certainly a skill that a clinical teacher needs.

Engeström et al. (1999) link knotworking with another concept, co-configuration. Avis (2009) describes “co-configuration [as] an emerging type of work in which customers and producers become partners and in which there is interdependency between multiple producers” (p. 153). In an earlier work Avis (2007) states that “Healthcare would constitute an example of co-configuration work with the relationship between medical practitioners of various specialisations networking collaboratively to address the needs of particular patients” (p. 172). For co-configuration work in the case of this study, substitute clinical nurses and clinical teachers for medical practitioners and students for patients.

Chapter summary

This chapter has presented a review of the literature surrounding clinical teachers and clinical teaching. Making sense of the literature is complicated by the various terms used for educators and forms of placement used around the world. There is a need for further research to be undertaken in the area. Many nurses come to the role being experienced clinicians however they have little if any preparation in teaching and

having to learn the job 'on the run'. It was also identified that it may take many years to develop into an expert clinical teacher.

Being a clinical teacher is a complex job, having to perform many juggling acts in the role. Different roles are required, an educator who is knowledgeable, an assessor of skills and knowledge, a negotiator and a provider of support. Work has been done on identifying the attributes of clinical teachers as this has been identified as having an effect on the development of the student, often based around personal attributes of the clinical teacher such as being approachable and a good communicator.

Workshops were seen as a common way of helping to prepare both new and to update ongoing, clinical teachers and could act as debriefing sessions for the participants and as a community of practice. Where gathering the clinical teachers together was not possible other forms of information dissemination was used, such as making use of CD rom technology and on-line learning methodologies.

Two major problems related to assessment were identified in the literature. Failure of clinical educators to fail students when they were not performing to standard and what is called 'grade creep' where higher grades are given than corresponding units. Some similar reasons were identified for these occurring in various studies including not understanding the assessment tool, the relationship between the student and assessor, the subjective nature of assessment and the amount of time the assessor can spend with each student. A lack of evaluation of clinical teaching has also been identified.

Benner's (1984, 2004) novice to expert concept, Pedagogical Content Knowledge and finally Engeström's (1999) description of knotworking help inform later discussions on the role and work of clinical teachers and were relevant to discuss here. It is now appropriate to move on to a chapter discussing the methodologies and methods used in this thesis.

Chapter 3:

Methodology and methods

Introduction

This chapter will present details of the research methodology and methods used in this study. The aims of the study are to critically examine the factors that have an impact on how the clinical teacher is able to perform this role. In addition it is proposed that an understanding of these factors can aid in the professional development of a highly accomplished clinical teacher in nursing education. It is recognised that good support for students leads to a better experience and greater skill development (Gillespie, 2002). Therefore more attention and research into how clinical teachers are supported and developed and the effect this has on student learning and practice is warranted. A socio – cultural theoretical perspective is taken in this study due to the nature of the work of the clinical teacher being framed within social interaction in the workplace. The methodology and methods selected as appropriate to explore such interactions and to understand these aspects are qualitative in nature.

A descriptive qualitative study using elements of a case study approach (Holloway & Wheeler, 2002; Luck, Jackson, & Usher, 2006; Stake, 2000) was chosen as the most appropriate research design for the remaining research aims. A variety of data sources were used; these included clinical teachers themselves, students who are taught by the clinical teachers, the clinical assessment documents and finally workshops held to inform and educate the clinical teachers before clinical placements. Some may call this a generic approach to qualitative research; however, it will be argued that this is appropriate in the case of this research study. A description of the methods of data collection will be presented followed by a description of the setting and the rationales for the various sources of data used. The chapter will finish with a discussion of the way data were analysed, the concept of triangulation and its relevance to the study, including a commentary on theorising in relation to data analysis. The approach to theorising is consistent with the approach used to guide the study, which will now be outlined and further developed.

Methodology

Taking a generic approach (to use the authors term) does not mean the research should be without the merits that are accorded to acceptable research. What it does mean is

... that the responsibility for laying out the merits of a particular study lies with the author(s). Qualitative researchers cannot invoke a known method in a few words. Enough detail about the study, the approach, and the methods needs to be included so that the reader can appropriately evaluate the research.

(Caelli, Ray, & Mill, 2003, p. 8-9)

These authors continue:

Accordingly, we posit that research reports aiming for credibility as generic qualitative research must address the following four key areas:

1. the theoretical positioning of the researcher;
2. the congruence between methodology and methods;
3. the strategies to establish rigor; and
4. the analytic lens through which the data are examined.

(Caelli, et al., 2003, p. 9)

This view is supported by Sandelowski (2000) who states that “The obligation of researchers is to defend their sampling strategies as reasonable for their purposes” (p. 338) which is one of the elements in the above list.

To do this it is necessary to review these four key areas in more detail. In relation to the positioning of a researcher, Caelli et al. (2003) state “We argue that, at a minimum, researchers employing a generic approach must explicitly identify their disciplinary affiliation, what brought them to the question, and the assumptions they make about the topic of interest” (p. 10-11). In a work such as this, this information is usually given in the introductory chapter as is the case here. Methodology and method are two terms that may ill-advisedly be used interchangeably and this often leads to confusion in qualitative research reporting. This can be further compounded when the term ‘techniques’ is used, where others talk of ‘methods’. Generally, though, most authors follow the lead taken by Nicholls (2009) where, commenting on other works, stated that he explored “four common methodological frameworks used in qualitative health

research (phenomenology, grounded theory, ethnography and discourse analysis)” (p. 638). In this article, Nicholls (2009) looked at methods which included interviews, observations and document analysis. This will be the approach taken here, with the methodology discussed first, followed by a description of the methods.

Caelli et al. (2003) comment that their “position is that qualitative researchers need to 1) articulate a knowledgeable, theoretically informed choice regarding their approach to rigor, and 2) select an approach that is philosophically and methodologically congruent with their inquiry” (p. 15). These aspects will be explicated throughout this chapter. Finally there is the question of the analytical lens through which the data are examined. Caelli et al. (2003) argue that the literature concludes that generic qualitative studies are superficial, only reporting on themes identified rather than taking this analysis further, using an analytic lens, and making sense of these themes. It will be strongly argued in relation to this aspect in the next section that this is not the case; there can be depth to the study.

Descriptive qualitative research

A qualitative research methodology was chosen for this study as it “...uses methods that are flexible and sensitive to the social context of the phenomena being investigated, recognising that multiple truths exist” (Smith, Bekker, & Cheater, 2011, p. 50). In the current study the view taken is that as the topic is social in nature a methodology that is able to address a social context is therefore appropriate. There is, however, a problem with this decision as there are multiple methodologies that come under the heading of qualitative research. Smith et al. (2011), drawing on Tesch, suggest that “...with more than 40 methods available [it] can be challenging to choose an appropriate ... method that meets a study’s aims” (p. 41). Smith et al. (2011) argued that in some cases a generic design is appropriate. There are grounds to accept this as a valid argument as many of the methods available focus on particular aspects or views of the topic or subject of the study. This is supported in the literature, for example:

Merriam takes the view that generic qualitative research studies are those that epitomize the characteristics of qualitative research but rather than focusing on culture as does ethnography, or the building of theory as does grounded theory, “they simply seek to discover and understand a phenomenon, a

process, or the perspectives and worldviews of the people involved” ([Merriam 1998] p. 11) (Caelli, et al., 2003, p. 3).

Sandelowski (2000, 2010) makes a similar point in her discussion of “Qualitative description”. Sandelowski (2000) comments that “... the qualitative descriptive study is the method of choice when straight descriptions of phenomena are desired. Such study is especially useful for researchers wanting to know the *who*, *what* and *where* of events” (p. 339 original italics). Stake (2010) also supports this view, stating that “The best qualitative research... is seldom about how people feel; it is about how things happen, how things are working” (p. 63).

Sandelowski’s views resonate well with the approach used in this study and therefore will be explored in more depth. Her original work was published in 2000 and was revisited in 2010, when the author claimed that “The article [referring to the original 2000 publication] has generated several misconceptions” (Sandelowski, 2010, p. 77). Sandelowski (2000) argued that qualitative description is a method that should be considered “... as a distinctive method of equal standing with other qualitative methods, although it is one of the most frequently employed methodologic approaches in the practice disciplines” (p. 335). The point is made repeatedly throughout the earlier paper that “The description in qualitative descriptive studies entails the presentation of the facts of the case in everyday language” whereas other methods suggest that they are looking at the data through a perceptual lens of the particular methodology where a researcher “re-present events in other terms” (Sandelowski, 2000, p. 336). Sandelowski (2000) refers to “grounded theory, phenomenologic, ethnographic, and narrative studies” (p. 336), all methods where an analysis is made of the participants’ actions or utterances, whereas in this study the language of the participants through their comments and documentation is used to provide the everyday language of the area under study.

This is not to say that any single research endeavour will not make use of aspects of particular methodologies; as Sandelowski (2000) points out “Indeed, qualitative work is produced not from any “pure” use of a method, but from the use of methods that are variously textured, toned, and hued” (p. 337). In her 2010 commentary on the earlier paper, Sandelowski (2010) also remarks that “Qualitative descriptive studies may begin

with a theory of the target phenomenon or a framework for collecting or analysing data, but that does not mean a commitment to stay with this theory or framework” (p. 80).

Case study

There are several authors who write about the case study approach, with Yin (2010) and Stake (2000, 2010) referred to in most texts. Stake’s work will be the main focus here as he tends to take a more qualitative approach to his work, whereas Yin “focuses on the quantitative framework” (Holloway & Wheeler, 2002, p. 220). Antoniou and Stierer (2004) also question Yin’s view of case study research saying that:

Although Yin highlights the case study as both quantitative and qualitative, we are disappointed that he repeatedly seeks to prove the “scientific” status of case study methods by comparing them with quantitative methods such as experiments and surveys (p. 379).

Stevenson (2004), in a table classifying case studies, also situated Yin in a positivistic paradigm while placing Stake in an interpretative paradigm (2004, p. 42). It should be noted that Stake (2000) says that “Case study is not a methodological choice but a choice of what is to be studied” (p. 435), yet in most text books case study research is presented as a methodology. The nature of case study is not uniformly agreed upon, but for the purposes of this thesis the following definition by Stake (2000) is used; “A case study is both a process of inquiry about the case and the product of that inquiry” (p. 436).

There are many alternative definitions of case studies, the following being congruent with this study. Luck, Jackson and Usher (2006) define case studies as “a detailed, intensive study of a particular contextual and bounded, phenomena that is undertaken in real life situations” (p. 104). Holloway and Wheeler (2002) describe case study as “an entity studied as a single unit, and it has clear boundaries and a specific focus” (p. 220). They continue: “The boundaries of the case should be clarified in terms of the questions asked, the data sources used and the setting and person(s) involved” (Holloway & Wheeler, 2002, p. 220). In discussing boundaries, Luck et al. (2006) state that “These boundaries are explicitly set via the description of the locale, culture, group process or institution” (p. 104). They continue “Within the case, there is coherence. The single

population or single subject of the study can be readily identified ... [and] Importantly, the case boundaries need to be congruent with, and explicit in, the research question asked and data collection methods used ...” (Luck, et al., 2006, p. 104). These boundaries should be defined at an early part of the research but a researcher will have to understand that they may change as the research progresses. Within the current study this was the case, the boundaries were the clinical teachers and their work and development, although as noted there were changes that occurred in the workshop element of the study.

Stake (2000) talks about three different styles of case studies; he calls these the intrinsic, the instrumental and the collective (p. 437). It is the second style of case studies, the instrumental, which was the focus in the current work. In the intrinsic case study it is the case itself that is of interest, without any wider interest than the case itself. Its purpose is not to build theory nor is it to generalise outside of the case. In this way it has a narrow focus (Cousin, 2005; Stake, 2000) unlike the next two described. Collective case studies are where several case studies are carried out and the information obtained used to better understand a given situation, similar to the way an instrumental case study is used. Stake (2000) does not see these as distinct entities rather as a continuum, with overlap of the functions at the junctions:

The instrumental case study is used where there are wider interests than just the case, in fact the case is a way of understanding a wider issue, and is the vehicle that lets us see the issue at hand. Cousin describes it in this way; “... the researcher explores a case as an instance ... of a class ... in order to shed light on an issue concerning the class ... that can tell us something about ... [that class] in general” (p. 422).

In this study the case is to understand the work of the clinical teacher better, with the wider interests as outlined above being the clinical setting, the students the clinical teacher works with, the workshops the clinical teachers attend and the assessment tools use in their work. Each of these can be considered as a case in itself to better understand the main case, the work of the clinical teachers. The boundary is the context within which this group of clinical teachers work, with the clinical setting, students, workshops, clinical assessment forms and the clinical teachers themselves acting as the

information to inform the overall case. The way this is conceptualised is represented in the diagram below, Figure 2.

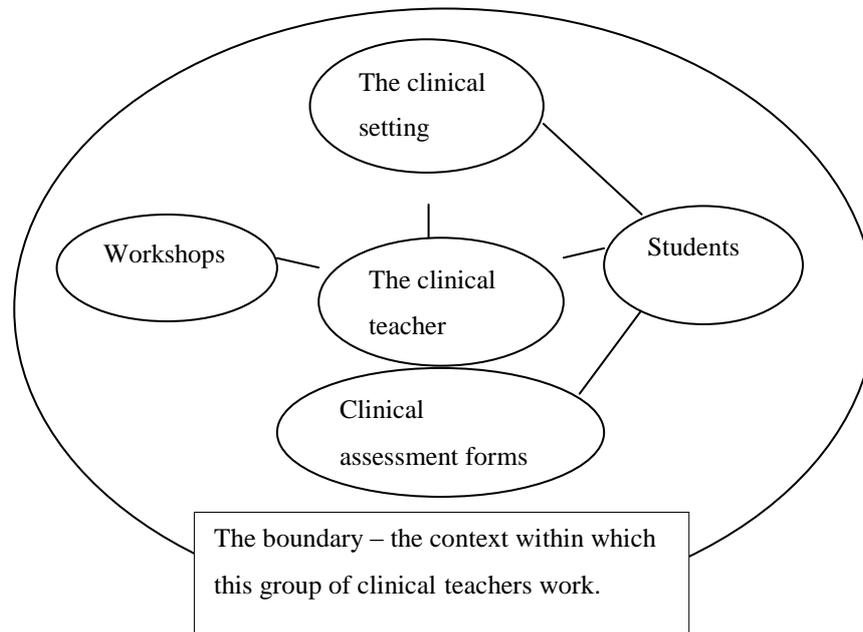


Figure 2 Case study boundaries

To study the particularities of the case Stake (2000) suggests drawing on the following points:

- The nature of the cases
 - The case's historical background
 - The physical settings
 - Other contexts (e.g., economic, political, legal, and aesthetic)
 - Other cases through which this case is recognized
 - Those informants through whom the case can be known
- To study the case, to show particularity, many researchers gather data on all of the above (pp. 438-439).

In the current study, the nature of the case, the settings, the context and the informants are the particulars that are drawn upon as data for the study.

Case study research, like all research, needs a question to organise the work. Stake (2000) describes this as a “conceptual structure ... organized around a small number of research questions. [which should be] ... not just information questions, [but are] ... issues or thematic lines” (p. 440). Stake (2000) continues “Issues are complex, situated,

problematic relationships” (p. 440). In this research the issues are around the complexities of the practice of the clinical teacher, the skills, knowledge and attributes needed to be an accomplished clinical teacher and how can an understanding of the skills, knowledge and practice of clinical teaching be used in the professional development of clinical teachers? The question is intentionally complex as there are many factors that can come into play in the clinical teachers’ support of students, which can make the work of the clinical teacher problematic. If the students are not well supported by the clinical teachers, they may not be well prepared for subsequent study, registration or practice.

A common thread in many of the works on case study research is the concept of generalisability, one of the reasons for the choice of instrumental case study design. Yin (2010) and those who follow the quantitative approach equate this with their notion of generalisation, whereas other authors such as Stake and McKee take a different approach. This is appropriately put by McKee (2004), who states:

The generalisation case study offers has been called naturalistic. ... We engage in this form of “naturalistic” generalisation when we read or listen to stories. ... It supports reflection and rethinking, enabling the reader to learn more about and from their own experiences. ... [It] also occurs when the reader, understanding the uniqueness of the case judges what ‘findings’ are applicable to their situation or needs and what are not (p. 7).

Qualitative researchers would describe this as transferability (see Holloway & Wheeler, 2002, Chapter 16 for example) and discussion on thick description is common in both case study and other qualitative research methodologies. Thick description is the term used to describe detailed accounts of the research undertaken, in particular the process and data collected “... so that the meaning and importance of behaviours and events can be fully understood” (Curtin & Fossey, 2007, p. 90). It is only through having this detail in the report of the study that a reader will be able to decide if the research is transferable to their own situation. To this end in the following section comments are made on the process used in the current study.

Stevenson (2004), with reference to the methods that are used in case study research, notes that “Typically, such techniques as observations, interviews and documentary

analysis are used to assemble a detailed or rich account of a single or multiple cases of” the area under study (p. 41). Analysis depends on the orientation of the approach taken but again, a “descriptive or narrative form of analysis” is more often used in line with the qualitative approach that many researchers use in case study work (Stevenson, 2004, pp. 42-43). Luck et al. (2006) argue that multiple methods can be quite justified in case study research saying that the arguments they put forward “supports our contention that within a defined epistemological, ontological and methodological framework the researcher can congruently argue the rigour of utilising multiple methods in their case study research” (p. 106).

In writing a report some decisions have to be made on how to report the research. Stake (2000) raises these in the form of five questions:

1. How much to make the report a story;
2. How much to compare with other cases;
3. How much to formalize generalizations or leave that to readers;
4. How much to include description in the report of the researcher interacting;
5. Whether or not and how much to anonymize (p. 448).

Applying Stake’s five questions to this research the report is not a story, the data is presented as it was given to me, it is the participants own telling. There are references to other cases where this has helped to make sense of the data; some may also consider that some of the data sources could be considered sub-cases within the wider case of the research, for example the documents that were one data set. Throughout this work, as data analysis occurred, the data from one source was constantly companied with the data arriving from other sources to help make sense of, and to direct future data collection. I have made some generalisations when analysing data and synthesising findings however the reader may make generalisations from the work as well. Within qualitative research there is a view that when the “researcher is the instrument in semi structured or unstructured qualitative interviews” (Pezalla, Pettigrew, & Miller-Day, 2012, p. 166) it is necessary to report on a researcher's relationship to the participants in the study. This occurs later in this chapter when the setting and context is described. In relation to Stake’s final point as to anonymity, the participants have been de-identified.

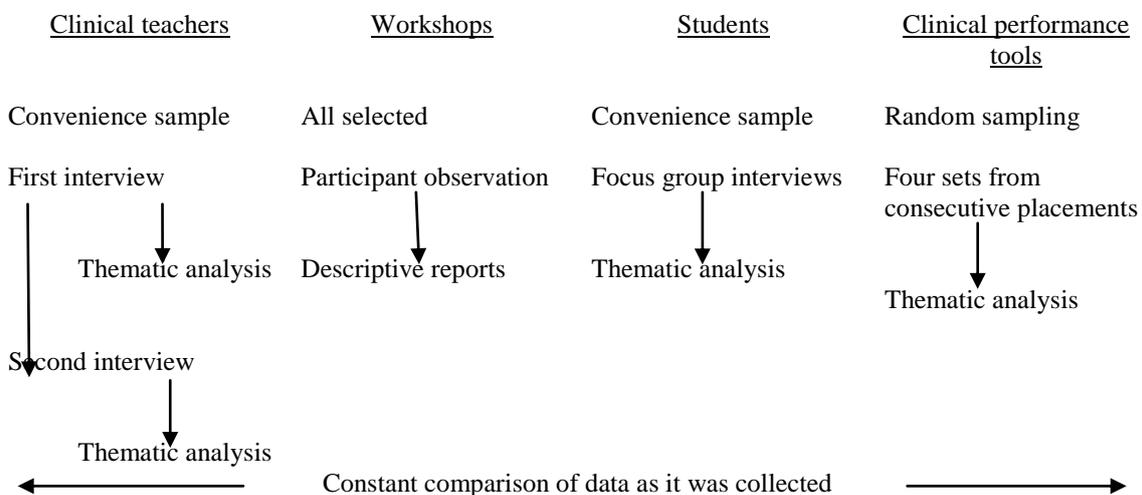
This section has described the methodologies used in the current study, it is now appropriate to describe the methods used in this study.

Context of the study

The study was set in one School of Nursing within the metropolitan area of an Australian state capital. The clinical teacher participants were employed by the school either as sessional clinical teachers (4) or as combined clinical teachers/skills teachers (2). In the latter role, during semester time they taught in the nursing skills laboratories and when students were on placement they were in the role of clinical teachers. Student participants were undertaking an undergraduate degree in nursing leading to registration as a Registered nurse (Div 1 nurses at the time of the study) in Australia. Some of the students were completing the degree as direct entry three year students while others were already Enrolled nurses (Div 2 nurses at the time of the study) completing a shortened course of two years.

The workshops, where participant observation was conducted, were ones run by the school for their clinical teachers prior to each semester of clinical placement. All that occurred in the data collection period were included. Convenience sampling was used to recruit the clinical teachers and student groups for the student focus groups. The clinical appraisal forms were a random sample selected by the clinical unit of study coordinator from the ones submitted for unit results. It was felt that this was the most appropriate process due to the possible issues of coercion due to the position held by myself within the school, being both a clinical and year coordinator. Further details on the individual processes are given in the next section.

Table 5
Data types, selection and analysis



Methods

Individual clinical teacher interviews

Clinical teachers were included in the study to investigate their perception of the role. They are the best source of information as they are actually performing in the role. Any other view would be second hand. This was consistent with the aims of the study. Initially interviews were held with six clinical teachers; half of whom were considered to be novice clinical teachers while the other half could be considered experienced. This ratio was used to gain a balance of views from a range of clinical teachers as the literature indicated that there were differences between clinical teachers with various levels of experience. Comments about new clinical teachers being “thrown into the deep end” with little support and preparation is an example of what a novice may be better able to talk about than an expert who may have forgotten what it was like at the start of their experiences. It was planned to hold a second interview with all of the initial participants. In the end it was only possible to hold interviews with four of these clinical teachers, two novice and two experienced due to two of the participants were no longer contactable. The aim of this second interview was to follow up on information given in the first interview and to allow the participants to comment on findings from the data analysis, also whether there had been changes in their practices and views after attending the series of clinical teacher workshops. As most of the participants had left the employment of the school and/or did not attend many of the workshops this latter aim was not able to be met. A question protocol was used for each interview to ensure that all participants were asked the same questions (See Appendix 1). The participants were asked to elaborate on answers if appropriate and/or extra questions were asked as other issues were raised or to draw out further elaboration if warranted. All interviews were audio recorded and transcribed by myself.

Student focus group interviews

As students are the recipients of clinical teaching it was felt important to obtain a student view on aspects of the clinical teaching role and the effect this has on their learning. A focus group interview process was used as it was both time efficient, being able to gather many views in one session, and participants are more likely to discuss aspects with peers there to support them.

As was the case for the individual clinical teacher interviews, a question protocol was used to ensure each group of nursing students was asked the same questions (See Appendix 1). Students were asked to elaborate on their answers as appropriate, to obtain greater depth to their answers or to clarify statements they made.

To aid in maintaining confidentiality in the recordings the students were asked not to name clinical teachers or venues in their comments. Generally they did this although several names were removed in the transcriptions; it was noted that the comments where names were mentioned were positive ones.

Clinical teacher workshop observations and documents

A third source of data was the clinical teacher workshops. Within qualitative studies there are two types of observation activities a researcher may carry out. The first is called non-participant observation. “Here the researcher remains either entirely detached, or at least marginal to, the participants he/she is observing” (Nicholls, 2009, p. 641). Nicholls (2009) suggests that this style is viewed as more objective; however he continues “Some researchers argue that participant observation provides a richer experience of the complexities and nuances of a phenomenon, and that participant observation is infinitely preferable to the false objectivity of the non-participant observation” (p. 641). Participant observation was used where possible for this study as it was felt that being part of the workshops would bring about a clearer understanding of the participants by being one of the participants. The role of non-participant observer occurred in some sessions where these were conducted by other staff members (see Table 6). The following section outlines aspects in relation to the workshops in more detail.

Table 6
Content of workshops

| | Semester 1 2008 | Semester 2 2008 | December 2008 | Semester 1 2009 | Semester 2 2009 |
|---|---|---|--|---|---|
| Content arranged and presented by myself | Nil | Failing to fail students – what is happening? | Introduction to simulation The affective domain/professional practice | Simulation session | Documentation – CPAFs & The Bondy Scale |
| Content prepared, presented or planned by other nursing academics | Professional issues and assessment | Effective feedback | Nil | Update and changes within the school | A day in the life of a Clinical Teacher Overview of HBBN curriculum |
| Traditional content | Administration (Forms, Information etc.) 2007 Debriefing Session Clinical Updates (Coordinated Care, Mental Health, Acute Care) | New Clinical Teachers Orientation Administrative information Clinical Debrief/Brief Session | Administrative matters Debriefing session | Administrative update Unit of study update | Clinical Learning Office Orientation Overview of 2 nd Semester Units |

Taken from Workshop programs (see Appendix 2).

Several sets of information were collected for each workshop where data were collected. The first was the program for the workshop. The program outlined the sessions that were being held and served as the source for the content to which the clinical teachers had been exposed. The second was my field notes and reports. Field notes are documents written by a researcher for their own use (Wolfinger, 2002) whereas reports are documents written for other uses within the school in relation to aspects of the whole of the workshops. These field notes were written after each workshop with comments about the different sessions. Sometimes these were quite superficial while others had more depth. The content of these notes were informed by the research question and recorded information that was seen as helpful towards understanding the role of the workshops in clinical teacher development. It should also be noted that I was not always present at all sessions run by other staff members due to teaching and other commitments, so data on these aspects are incomplete. The third set of data was material generated in education sessions presented in these workshops by both myself and other staff members. Due to the nature of individual sessions, in some cases there was no material produced while in others there was some, such as information written by groups to present later in the session from small group discussions of topics.

Student's summative clinical assessment reports

Documents are part of modern day life; therefore as Nicholls (2009) states, “Not surprisingly then, qualitative researchers are very interested in the role played by documents in defining who we are and what we do as a people” (p. 643). Documents can be looked at through various “lenses” depending on the methodology being used by a researcher. Nicholls (2009) gives examples of three different methodologies and the way each may view documents, historians, linguists and postmodernists. In the case of this study, the approach taken is aligned to Nicholls (2009) third example: “The third group are postmodernists who, like linguists, are interested in language, but ask instead what the text makes possible and what it denies” (p. 643). In this study the question is what are the clinical teachers saying about the students, and what are they are *not* saying, the ‘denies’ in Nicholls’ quote (which is perhaps even more important). Seeing what is not there was a matter of making a professional judgement based on my experiences over many years as an educator reading such documents. In some cases the

'gaps' were used as part of the questions put to the interviewed clinical teachers to either support or refute my judgements.

Nursing student's summative clinical assessment reports were collected from four cycles or rounds of clinical placement that aligned with the clinical teacher workshops included in the study. These forms are constructed by each school of nursing and have to fit within certain requirements of the accreditation body, at the time of this research this was the Nurses Board of Victoria. The forms used at the research site are called the Clinical Performance Assessment Form (CPAF) and changed over the course of the research. In the first collection round the form was different to later collection rounds, as the school made changes to the forms between the first and subsequent collections. This will be commented on in more detail in the next chapter. Further changes were also made, however these were only in the layout to condense the form and not the content which remained the same and therefore remained comparable. (Samples of each form can be found in Appendix 3). Sets of the students' summative clinical assessment reports were collected. No attempt was made to link each clinical teacher participant to the collection of these documents. This would have required the unit of study coordinators being aware of the participants, which may have constituted a breach of requirements for ethical conduct of the research.

The collection of the documents was arranged through the respective unit of study coordinators, there being different ones each semester. They were asked to provide sixteen documents each from novice and experienced clinical teachers; thirty two in total. The unit of study coordinators were given a list of the employed clinical teachers notated to indicate which ones were considered novice and which ones as experts to aid this. As each clinical teacher would have up to eight students at a time, the unit of study coordinators were asked to ensure that the documents came from at least two and up to four different clinical teachers and to mark those from each one, i.e. CT 1 CT 2 etc. It was usually possible to group the different clinical teachers due to handwriting or style of presentation of their comments as some typed their documents. The unit of study coordinators were asked to de-identify the documents as previously outlined.

Each document was then transcribed into a Word file and analysis was carried out using the Weft QDA program (Fenton, 2006). Each clinical teacher's documents, as outlined

above, were identified separately according to the sample and whether they were a novice or an experienced clinical teacher.

Timeline of data collection

Data were collected over an extended period of time, as can be seen in Table 7. The first set of data collected were the Clinical Performance Assessment Forms; obtained in early 2008 after the students had finished their Semester 2, 2007 clinical placements. Further forms were collected for the following three clinical placement periods, the final one being for the midyear 2009 placement period; thus giving a total of four sets of forms as data.

During this period five clinical teacher workshops were held. Four of the workshops where data were collected were held at the start of semesters 1 and 2 in both 2008 and 2009. An additional workshop was held in December 2008 as a debriefing session and to introduce the clinical teachers to simulation which would be introduced into a revised curriculum commencing in the following year. The second semester 2007 workshop is also included as this was the starting point for the workshop data.

Clinical teacher interviews commenced in early 2008 after recruitment in the first clinical teacher workshop and continued over the rest of that first semester. A further set of interviews were held with the original participants who remained available (see Table 9 for details) at the end of 2010 to seek clarification of information after analysis of data from their original interviews. Focus group interviews were also held with students at this time. Details of the data collection periods can be found in Table 7.

Table 7

Timeline of data collection and analysis

| 2007 | January | February | March | April | May | June | July | August | September | October | November | December |
|-----------------|--------------------------------------|----------|--------------------------|--------------------------|--------------------------------------|------|--------------------------|-----------------------------|--------------------------------------|--------------------------------------|----------|--------------------------|
| Data collection | | | | | | | | Clinical teacher meeting | | 1 st CPAF clinical period | | |
| | | | | | | | | | | | | |
| 2008 | January | February | March | April | May | June | July | August | September | October | November | December |
| Data collection | Clinical teacher interviews | | | | | | | | | | | |
| | 1 st CPAF clinical period | | Clinical teacher meeting | | 2 nd CPAF clinical period | | Clinical teacher meeting | | 3 rd CPAF clinical period | | | |
| | | | | | 1 st CPAF analysis | | | | 2 nd CPAF analysis | | | Clinical teacher meeting |
| | | | | | | | | | | | | |
| 2009 | January | February | March | April | May | June | July | August | September | October | November | December |
| Data collection | 3 rd CPAF clinical period | | | Clinical teacher meeting | 4 th CPAF clinical period | | Clinical teacher meeting | | | | | |
| | | | | | 3 rd CPAF analysis | | | | 4 th CPAF analysis | | | |
| | | | | | | | | | | | | |
| 2010 | January | February | March | April | May | June | July | August | September | October | November | December |
| Data collection | | | | | | | | Clinical teacher interviews | | | | |
| | | | | | | | | | | Student focus groups | | |

Notes

1. Where the area is shaded reports/analysis of data are available.
2. One clinical period occurs from October to February and the second from May to July each year

The process of research

The setting/context

The School of Nursing and Midwifery in which the study was conducted has approximately 1000 students enrolled in a three year Bachelor of Nursing course. The school is situated in a metropolitan setting and sources most of its clinical placements from large metropolitan hospitals. A Bachelor of Nursing course has been running on the campus since the early 1990s. During the period of the study a curriculum change occurred. As the old course was ‘taught out’ the only data that were affected were the student focus groups when insufficient third year groups who studied under the ‘old’ curriculum were able to be recruited and therefore two second year, ‘new’ curriculum groups were recruited. The effect of this is discussed later when that data is reported and analysed. Students in the course undertake a range of clinical placements in order to satisfy the requirements of the national registration body. Table 8 set out the year, semester and type of placement undertaken by the students at the time of the study. A range of clinical venues are utilised for the placements which include major metropolitan hospitals to small rural hospitals and may include other places where Registered Nurses are employed. It is not cost effective to employ a clinical teacher where there is only one or two students placed, and in this case preceptor type arrangements are used. Some clinical teachers tend to prefer one venue while others work across the range of venues used by the School of Nursing in which the study was conducted.

Table 8

Clinical placements by year level and duration at the time of the study.

| | Semester 1 | Semester 2 |
|--------|---|---|
| Year 1 | No placement | Low level acute care or nursing home (3 weeks) |
| Year 2 | Acute care (2 weeks) Aged care (2 weeks) | Acute care (2 weeks) Mental health (4 weeks) |
| Year 3 | Acute care (4 weeks) | Acute care, aged care, paediatrics or mental health elective (4 weeks) Consolidation (mainly acute care) (4 weeks) |

Clinical teachers are registered nurses employed by the School of Nursing on a sessional basis for the periods when students are on clinical placement. They work with a group of eight (8) students within the placement venue. In hospitals the students are usually assigned to wards, usually two students to a ward, therefore each clinical teacher covers four wards. Placements occur from Monday to Friday and both early (0700 to 15-30) and late (1300 to 21-30) shifts are covered. In some cases another clinical teacher with their group of students will be working on the opposite shift in the same area.

The students have two assessments carried out while they are on each placement. The first is a formative assessment at the midpoint of the placement to give them feedback on their progress. This did not count towards their grading (summative assessment) for the unit of study at the time of the study. A summative assessment is carried out at the end of the placement and this gives the students their grade for the unit. During the course of data collection this was either a pass or fail grade. The assessment forms changed during the data collection period, the first set collected had both the formative and summative assessment entered on the document while the later ones were separate documents although formatting changes did occur reducing the size of the documents however not the content. (See Appendix 3.) The later forms used a scoring scale (the Bondy (1983) scale) against which students must gain a minimum score to pass the unit. The students only had to submit the summative forms at the end of their placements therefore the formative appraisals were not available for the later documents that served as data.

The conduct of the study

This section of the thesis will describe the way the study was conducted. Besides ethical committee approval the then Head of School was approached for permission to contact clinical teachers and students to recruit them as participants and to access the clinical assessment forms, which was granted. The following section will describe this in more detail after which some comments are made about the iterative process used in the study.

Iterative process

Due to the nature of the study an iterative process was used in data collection. This is in line with the nature of the study where information from an earlier intervention is used to inform and develop later interventions. The data collection occurred over a three year period (see Table 7, for details) with information from earlier data and analysis informing later work. This occurred particularly in relation to the content of the clinical teacher workshops as information from the data collection and analysis, concurrent literature reviews and developments within the school where the research was conducted informed the educational/development sessions. The second interviews with the clinical teachers can also be seen as an iterative process as the aim in these interviews was to seek clarification of information that had come out of earlier data, in particular the first interviews and the analysis of comments from the clinical assessment forms.

Clinical teachers

For the purposes of this study clinical teachers of students in the second year acute care placements were the main focus. There were several factors for this decision. First, the majority of clinical teachers are used during the acute care units in the second year of the course. The first year clinical unit was only run in one semester whereas there was a similar acute care clinical unit in both semesters in second year. A final factor is that I was the third year coordinator and a third year clinical unit of study coordinator; thus by using second year clinical unit it minimised any ethical problems that could be perceived around coercion to participate if third year units were used.

Recruitment of clinical teachers was via a verbal request during a clinical teacher workshop with e-mail information sent to all clinical teachers employed in the school at that time (via the Clinical Learning Office staff) and by word of mouth with several colleagues. If the clinical teachers were interested in participating they were asked to contact myself. Five participants were recruited in this way. The sixth participant was recruited by a colleague who made them aware of the research as they were employed after the initial invitations were sent out. All clinical teachers who responded in the affirmative (there were two who declined and others did not respond) were included in the study. The interviews took place at a venue nominated by the clinical teacher. In some cases the locations were offices on the university campus, while others took place

in convenient rooms while the clinical teacher was on placement with students. Each interview lasted between 30 and 40 minutes and was audio recorded. As part of the initial interviews permission was gained to return to the interviewees if there were further questions to be asked.

Participants were deemed to be either novice or expert based on their previous experiences with clinical teaching of undergraduate nursing teaching. Those classed as novice had less than one years' experience, in the case of two their current employment was their first experience, whereas those classed as experienced had more than a years' experience. All of the participants either were, or had worked, in the acute care units from which the clinical appraisal tools were collected.

At the time of the second round of clinical teacher interviews only four of the original six participants were contactable. Of the remaining two no contact information was available for one while no response was received from the second using the contact information available. The first of these clinical teachers had her employment with the university terminated soon after the original interview; however the reason for the termination was not able to be ascertained. The lack of this information may have been a significant loss to the study for if the reason for the termination was due to lack of experience or a lack of development this could have been significant. A second interview with the participant may have elicited this information. The second one, an experienced clinical teacher, had taken leave soon after the first interview and had not returned at the time of the second interview. In view of their possible lack of clinical teaching over this time and further difficulties in contacting the second clinical teacher, they were not followed up any further. A secondary consideration was that this maintained the balance between novice and experienced clinical teachers within the interview groups, there now being two from each group. This reduction in the number of participants did reduce the quantity and quality of the data however this was only was of the four data sources in this modestly sized study. It also highlights the transient nature of these positions. It is also worth noting that only one of the original six clinical teachers was actually still employed in the school when the second round of interviews took place.

Other clinical teachers were peripherally involved in the study by being participants in the clinical teacher workshops and the data collected there. The following table, Table 9, gives information on the six clinical teacher participants.

Table 9**Information on Clinical Teacher participants**

| Identification | Experienced or novice | Years' experience as nurse | Years' experience as clinical teacher | First interview | Second interview | Workshops attended |
|----------------|---|----------------------------|---------------------------------------|-----------------|--|--------------------|
| CT1 | Novice Had critical care background | 10 | 0 | Completed | Completed | 1 |
| CT2 | Experienced Had critical care background | 15 | 1 | Completed | Completed | 2 |
| CT3 | Experienced Paediatric background | 10 | 5 | Completed | No* No longer employed within the school | 2 |
| CT4 | Novice Educational background in post-graduate and medical education however not with undergraduate students | 10 | 0 | Completed | Completed | 0 |
| CT5 | Novice Recent graduate from nursing course with previous educational background | 2 | 0 | Completed | No* (employment was terminated by the school soon after the first interview). | 1 |
| CT6 | Experienced Mainly aged care background but taught in low level acute care as well. Had taught for other institutions in this role | 20+ | 10 | Completed | Completed | 4 |

*As no longer employed by the school contact details were not available for second interview.

Students

Student nurses within the School of Nursing and Midwifery were involved in this study in two ways. The first was through the collection of their Clinical Performance Assessment Forms and secondly through their participation in focus group interviews.

The Clinical Performance Assessment Forms for students completing a second year clinical placement were collected over the course of four semesters. These were made anonymous by the unit coordinator by removing both the names of the clinical teacher and student from the documents prior to access by myself. A total of 32, 16 from novice and 16 from experienced clinical teachers were requested each time. However these numbers of forms were not always provided (see Table 14, next chapter for actual numbers).

Five focus group interviews were held with students. A convenience group sampling method was used. The groups were recruited via their clinical teachers, one of whom was a clinical teacher participant in the study, who put the request and provided the written participant information to their students. All the focus group interviews were held at the clinical venue during what would have been the students' debriefing time. In all a total of 34 students participated due to student absentees on the day the focus group interviews were held.

Although the plan was to interview third year students who had been studying during the summative assessment document collection time, this did not prove possible for all of the focus groups. Four third year student groups were identified as potential participants, with one of these declining to be involved. Two second year groups were asked to participate and these agreed. Therefore three third year and two second year focus group interviews were held. Further details are given when this data is discussed in the next chapter.

Clinical teacher workshops

Each semester a workshop is held for the clinical teachers employed for that semester. A majority of clinical teachers attend. The aim of these workshops is twofold, to inform the clinical teachers about any changes in the course and clinical units and to act as an education/development session for them. Before discussing this aspect of the workshops it is necessary to report on my involvement with these workshops.

The researcher's role in relation to the content of the workshops

My role in relation to the clinical teacher workshops varied over the course of the data collection period due to ongoing changes in roles, responsibilities and curriculum within the school. The variation in the academic responsibilities changed my relationship with the workshops, which subsequently affected the degree of influence I had on the overall content of the various workshops that were held. Two roles were consistent throughout the data collection period. The first of these, not directly related to the study, was that of a clinical unit of study coordinator. All clinical unit of study coordinators were expected to attend the workshops, to brief the clinical teachers on their clinical units.

The second role held was that of the administrative organiser for the workshops. This involved arranging the date, time and content of the workshops in conjunction with the Administrative Assistant of the Clinical Learning Office. For the first workshop I was the acting clinical coordinator, normally responsible for arranging such workshops. Therefore from the perspective of research interests and role responsibility it was appropriate that I arranged the workshops. Prior to the second clinical teachers' workshop in the data collection sequence, there were changes made within the school, resulting in the appointment of a new course coordinator and a coordinator of teaching and learning. Part of the role with this second position included responsibility for clinical teaching within the school. Organisational responsibility for the workshops remained with myself. However, the staff member in the role of coordinator of teaching and learning wished to have input into the content of the workshops. Therefore for the second workshop one session was arranged by myself, while the rest of the content was either that traditionally produced, for example the briefing sessions by the unit of study coordinators, or sessions required by either the course coordinator or the coordinator of teaching and learning.

The third workshop, held in December 2008, followed the same pattern. One session was arranged by myself, while the other was arranged around the simulation laboratories and workshops to be introduced into the curriculum in 2009. There was no briefing session held as the workshop was not at the start of the semester; however this was replaced with a de-briefing session to discuss how the semester 2 clinical placements had progressed.

A similar pattern occurred with the final workshops. During this time another new position had been created in the school with the position of coordinator of teaching and learning being split into two roles, one for the academic aspects and one for the clinical aspects. The staff member who took on this new coordinator of teaching and learning (clinical) role left the organising of the workshops and some of the content to me while also requiring some specific content to be included. Table 6 previously presented outlined the content over the various workshops and who was responsible for its inclusion. The data for this table has been taken from the workshop programs that can be found in Appendix 2.

Data analysis

“Qualitative research, including qualitative descriptive research, always requires moving somewhere: that researchers make something of their data” (Sandelowski, 2010, p. 79). It is through analysis that a researcher makes something of their data. Drawing on the work of Ritchie and Lewis, Smith, Bekker and Cheater (2011) say that “Data analysis is an inductive process with the explicit aim of describing and interpreting the range of attributes associated with the phenomena being studied” (p. 41).

Within qualitative studies coding is used. “Coding is sorting all data sets according to topics, themes, and issues important to the study. Coding is for interpretation and storage more than for organizing the final report” (Stake, 2010, p. 151). This can be done manually or can be aided by computer programs. Two programs were used in this study. The first was Weft-QDA (Fenton, 2006), a freeware program that was used for the analysis of the clinical assessment forms. For the analysis of the interviews and student focus groups NVivo (QSR International, 2008) was used. Both of these tools were used in the same way, to mark and group data according to themes that had been identified through a thorough reading and re-reading of the data; Smith et al. (2011) term this the “data management” (p. 49) stage of the research process. This follows the general inductive approach as outlined by Thomas (2006) which was used in the analysis of the data collected. The codes applied were either words taken from the texts (the CPATs or transcripts of interview and focus groups) which identified the idea being coded or a descriptive comment which fitted the understanding of what was being

understood as being the idea being presented. (Details of the codes used may be found in Appendix 6 and 7.)

The next stage of the research process using Smith et al.'s (2011) table is the "Descriptive accounts" (p. 49) stage in which ideas are summarised and key points identified. This is described in the following chapter where the data is presented under its separate components. The final stage of the process is the "Explanatory accounts" (Smith, et al., 2011, p. 49) stage where associations are made amongst the data, explanations are sought and wider applications for these findings suggested. This is described in 'The complex roles of a clinical teacher and a model of developing expertise' chapter. These latter actions can be thought of as theorising and is also in accord with Weick's (1995) ideas which is now discussed in more detail.

Theorising

The nursing literature does not seem to address theorising therefore this section draws on other disciplines for this discussion. The author felt a need to comment on this to help explain the structure of the next two chapters. Saltmarsh, Sumsion and McMaugh (2008) see theorising as important, stating "One of the defining features of a profession is the distinct body of knowledge that it developed and has responsibility for ... Rigorous and deliberate *theorising* [emphasis added] and reconceptualising this knowledge base is essential for any field to remain vibrant and relevant" (p. 75). Saltmarsh et al. (2008) quoting Pring to explain theory thus:

Theory, according to Richard Pring, can be understood as "the assumptions which lie behind practice" and as "tightly organised systems of explanation" (Pring, 2004, p. 77). A more systematic explanation can be contrasted with ideas that are said to be "common sense" (p. 73).

It is the first definition that is relevant in the current study, the assumptions that lay behind practice since "To make these underlying assumptions explicit is to reveal a framework of beliefs and ideas which might or might not be called theory, depending upon its level of reflection and articulation" (Pring, 2004, p. 77). Pring (2004) adds that he believes that it is not possible to separate theory from practice and concludes "... that the much despised theory, in the sense of a framework of concepts and beliefs, far from being quite separate from practice, is the articulation of what is implicit in practice" (p.

78). This work has therefore, in the following two chapters, set out a framework of the concepts and beliefs of myself that have been developed from those found in the data. It is not claimed that ‘theory’ has been produced; however it does give an explanation of the practice of clinical teachers.

In an earlier commentary on a critique of a lack of theory in articles submitted to *Administrative Science Quarterly*, Weick (1995) states that “The process of theorizing consists of activities like abstracting, generalizing, relating, selecting, explaining, synthesizing, and idealizing” (p. 389). Weick (1995) sees five “parts” or stages in the path to theory, referring to “unconnected references” and “data by themselves” as being the early stages and quite unconnected from theory (p. 389) which is the data as presented in the next chapter. The following chapter, ‘The complex roles of a clinical teacher and a model of developing expertise’, will utilise Pring’s (2004) “framework of concepts and beliefs” (p. 78) as it relates to clinical teachers and their development. For completeness in this framework one method that can be used is triangulation, a technique used in this study.

Triangulation

One method to ensure rigour in the research is the use of triangulation. “Evidence that has been triangulated is more credible” (Stake, 2010, p. 125). Triangulation draws on different perspectives through the use of different participants and different sources of information; for example interviews, documents and research reports. McDonnell, Jones and Read (2000) say that in their research following such a process “enhanced rigour by contributing to the search for “completeness” of data, with each method adding a different piece to the jigsaw ...” (p. 387). It should be noted though that these variety of sources may not be available to researchers. There are alternatives in such cases:

You might have to rely on the verbal reports from three different people (or the information in three different documents) but have no other source of corroboration. In such situations, you would need to be concerned over whether the sources actually represented three *independent* [original emphasis] reports, forestalling the possibility that the reports were in some way linked. (Yin, 2010, p. 81)

In this study, as already described, four sources were drawn on: the clinical teacher workshops, clinical teachers, student nurses and, finally, the clinical assessment forms. Some of these gave greater insight than others; however, they all informed each other either through affecting the content of the clinical teacher workshops, the questions that were asked of clinical teachers and the students or in the analysis of the data. In this way different perspectives have been obtained to provide various views on the topic under study.

Ethical considerations

The National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007) gives guidelines to researchers on the ethical conduct of research involving human subjects. The guidelines say “The purpose of this National Statement is to promote ethically good human research. Fulfilment of this purpose requires that participants be accorded the respect and protection that is due to them. It also involves the fostering of research that is of benefit to the community” (National Health and Medical Research Council, 2007, p. 7).

As the study involved human subjects including both interviews with clinical teachers and students, and access to student information, approval to conduct the research was sought from the Faculty of Arts, Education and Human Development; Human Research Ethics Subcommittee. As access to the data sources was through the School of Nursing and Midwifery at the University, the Head of School’s permission was also sought in relation to access to clinical teachers, students and their documents.

Different techniques were used in relation to confidentiality and consent within the various data collection sets. For the clinical teacher interviews and students focus groups written information sheets and consent forms were used (See Appendix 4) to inform and gain consent. Verbal confirmation was included at the commencement of each recorded interview or focus group. The participants were also asked not to name any person or body during the sessions, and if they did, this information was removed at transcription. Codes were used to identify the participants in the transcripts produced from the interviews and focus groups. For the student assessment forms a third party (the unit coordinators) were asked to identify appropriate forms for the research and to copy them without identification, or if this was not possible to remove the identification before they were passed on to myself.

Summary

This chapter has outlined the methodology and methods used to collect and analyse the data for this study. A descriptive qualitative research methodology was chosen that was informed by elements of case study research with the basis for this choice explained.

The methods of data collection in relation to the various data sets used in the study were reported while the setting of the study was described. This has included the rationale behind the particular data sets which were collected, and the methods of analysis used to make sense of the data. The final sections of the chapter reported on the period of data collection and made some comments around the process used and theory behind the data analysis.

The following chapter will describe the data gathered, while the subsequent chapter will reflect and theorise on the data to gain the depth of understanding needed to take it beyond mere description, such as that for which some generic qualitative studies have been criticised.

Chapter 4:

Findings: Perceptions and practices of clinical teachers and clinical teaching

Introduction

In the previous chapter the methodology and the methods of data collection were introduced including the various sources of data that were used to gain an overall picture of the work and development of clinical teachers in relation to the education of students. The aims of this study are to critically examine the factors that have an impact on how the clinical teacher is able to perform their role and to propose how an understanding of these factors can aid in the professional development of a highly accomplished clinical teacher in nursing education. To meet these aims three questions were developed:

1. What are the complexities of the practice of the clinical teacher?
2. What are the skills, knowledge and attributes of an accomplished clinical teacher?
3. How can an understanding of the skills, knowledge and practice of clinical teaching be used in the professional development of clinical teachers?

To answer these questions data is required. This data came from a variety of sources that will form threads which will be woven into the fabric in the following chapter.

This chapter will introduce the data to the reader. So that they may gain a clear idea of the data it is presented here clustered under the data sources. Table 10 sets out these sources along with the names given to each data set as they appear in the following discussion. If the table is taken as a matrix in this chapter the data is presented and discussed along the vertical axis. In the following chapter the data is then compared across the horizontal axis to arrive at an integrated outcome for the final chapter of the thesis. As each set of data is presented the section will be completed with a summary of the material which will then lead into the discussions of the following chapter. These sections will be presented in the following order: the clinical teacher workshops, the clinical assessment tool analysis, the clinical teacher interviews and finally the student focus groups. To commence some comments will be made about changes that occurred

in the setting of the study during the investigation. The subsequent effects on aspects of the study will be explained and put into context.

Table 10
Data collected according to source

| The workshops | Clinical Performance Assessment Forms (CPAFs) | First Clinical Teacher interviews (held start 2008) | Second Clinical Teacher interviews (held end 2010) | Student focus groups (held end 2010) |
|--|---|---|--|--------------------------------------|
| First workshop (Semester 2 2007) | First placement (Semester 2 2007) | CT one | CT one | FG one (3 rd yr) |
| Second workshop (Semester 1 2008) | Second placement (Semester 1 2008) | CT two | CT two | FG two (3 rd yr) |
| Third workshop (Start Semester 2 2008) | Third placement (Semester 2 2008) | CT three | CT four | FG three (2 nd yr) |
| Fourth workshop (End Semester 2 2008) | Fourth placement (Semester 1 2009) | CT four | CT six | FG four (3 rd yr) |
| Fifth workshop (Semester 1 2009) | | CT five | | FG five (2 nd yr) |
| Sixth workshop (Semester 2 2009) | | CT six | | |
| Seventh workshop (Semester 1 2010) | | | | |

Changes that occurred over the course of the study

Over the course of the study changes occurred within the School of Nursing and Midwifery which had an influence on data collection and on my own professional involvement. The first of these was to the assessment document used by the school. The second was organisational in nature which did not have any major influence on the data collected although it did have some effect on the content of the workshops and the way these were arranged. These changes are outlined briefly to set the background prior to the presentation of the data.

Changes in the clinical assessment document used by the clinical teachers

Each School of Nursing and Midwifery is required to have an approved clinical assessment document in place for students' clinical placement. The exact format of this is left to each school, however the Nurses Board of Victoria (NBV) (2008), the

accreditation body in place at the time the study was undertaken, in their Standards for Course Accreditation, Standard 2.2 Criteria 6 states that:

There is the use of clinical competency assessment tools with specific reference to ANMC Competency Standards, Codes of Ethics, and Codes of Professional Conduct, as required for specific practice (p. 7).

At the commencement of this research the School of Nursing and Midwifery was using a Clinical Performance Assessment Form (CPAF) of only a few pages. (Samples of the three CPAFs that were in use throughout the data collection period can be found in Appendix 3.) The pages the clinical teacher and student had to write on consisted of three pages, one page where a Bondy rating scale was documented, one page for interim assessment and recommendations and one page for the final assessment. At the commencement of 2008 a new CPAF was introduced that was split into two documents, a Formative phase and a Summative phase document. The student was only required to submit the Summative phase document to the school. As part of these changes the clinical teachers/preceptors were asked to document information on the current ten Australian Nursing and Midwifery Council (ANMC) (2005) competencies (see Appendix 5) as well as to complete a Bondy rating of the student in both documents. This meant that the documentation sections of the forms went from the previous three pages to fifteen. Complaints were received from clinical venues and teachers in relation to the length of this assessment form. To address these complaints the layout of the form was changed from portrait to landscape format with condensing of the area for written comments so that there were two competencies per page rather than one and was the format for the final two CPAFs collected.

As the changes to the forms made them more specific with the clinical teachers being asked to comment on each of the ten ANMC competency areas it was assumed that there would be detailed comments to the student. Although these would not be formative comments as could be found in the first CPAF document as the formative document completed at the mid-point of the placement did not have to be submitted; comments made should be indicative of the strengths and weakness of the students and should still indicate whether the information from the education sessions in the clinical teacher workshops was being taken up by the clinical teachers. This will be commented on further in the section reporting on these forms.

Changes in roles and personnel at the research site over the course of data collection

Due to changes within the school different staff had various responsibilities regarding clinical supervision and responsibility for the Clinical Teacher workshops. The initial arrangement with the Head of School was that as long as I worked with the person responsible for the clinical aspects of the students education I would have a reasonably free hand with the content of the workshops.

Over the course of the data collection there were four different staff members with some degree of responsibility for these workshops. For a short period this was myself, while two other persons with responsibility for the workshops were generally happy to leave the content and running of the workshops to me as long as they were kept informed of what was planned. With the final person this proved more difficult as they wanted full control of the arrangements of the workshop.

The workshops

It is important to report on the clinical teacher workshops as they formed part of the research study. Primarily they are the devices that are used to help develop clinical teachers, clearly supported in the literature review. The content of the educational sections of the workshops is therefore important to report. The workshops were also a rich source of data that informed and supported findings in other areas of the data, therefore leading to triangulation.

I took a participant-observer role within the workshops. After each workshop a report was written that took the form of field notes used in this section of the thesis. The field notes were notes of what was viewed as relevant to the study, informed by the research question, but not collected in any other way (see following) from the workshops. In addition to this various sets of material developed or used in the workshops was collected and used as additional data. This included the product of small group work used to report back to the whole workshop and surveys post workshop. There has been no attempt to evaluate the workshops themselves, the data is provided to help set the scene of the support given to the clinical educators who are participants in this study and the similarity of these to the others reported in the literature.

As outlined in Table 10 there were seven workshops in the period of data collection in which this participant-observer role occurred. The participant roles ranged from arranger, coordinator and presenter to presenter and participant in others. Traditionally the workshops had several components; a session by the Clinical Learning Office (CLO) staff that was used to arrange contracts, availability and allocation to student groups and other administrative matters with additional time allocated for new clinical teachers as an orientation session; a session where the clinical unit of study coordinators talked to the clinical teachers about the upcoming clinical placements which also acted as a de-briefing session; and finally, educational sessions relevant to the clinical teachers including information on any changes occurring in the school if any. These educational sessions were usually based on issues that had been identified in the period prior to the workshop and which may have been suggested by one of several staff including the author, the academic staff member with responsibility for clinical learning, the Course Coordinator and the Associate Head of School. Two areas of the workshops related to the research study, the briefing/de-briefing sessions and the educational sessions presented in the workshops. These two sections are now reported.

Briefing/de-briefing sessions

In the briefing/de-briefing sessions it was usual for the clinical unit of study coordinators to attend and to present their units, in the form of a briefing of their expectations of the students, to the clinical teachers present. The types of information provided in these sessions included the form of assessment required in the unit, for example a care plan or reflective journal, or the types of skills the student had practiced in the associated theory unit and so should practice while on placement to consolidate their skills. On some occasions clinical unit of study coordinators did not attend the workshops, therefore the opportunity to brief the clinical teachers was lost. Over the course of the data collection period the number of sessions presented by the unit coordinators had decreased to the point where in the April 2010 workshop there was no session allocated to this. As a result in the last clinical teacher workshop, two commencing clinical educators made a request for information about the content students should know for the clinical unit which they would be supervising students on placement.

Common themes kept occurring in the de-briefing sessions, while in others a single issue was raised. The recurrent themes are the ones reported here as they align with the objectives of this thesis, while in most cases the single themes are local issues for either a single clinical teacher or in relation to a particular venue.

The most frequent issue raised was the support the clinical teachers receive from the academic staff at the university. In the first report on the August 2007 workshop it was commented that *'the clinical teachers expressed a strong feeling of not being support [sic] by the academic staff of the school'*; from August 2008 the following *'Some also felt that even though they had tried to gain support for academic staff in some situation they felt they had been left out there in the clinical field without support as unit of study coordinators were not contactable or did not return phone calls'* while from the last workshop for April 2010 it was noted that *'one of the experienced clinical teachers present ... asked about contacting school staff outside of the usual office hours'*. There were varying views on this. In the December 2008 workshop not all clinical teachers felt unsupported; for example:

This comment led into another one about the availability of academic staff and visits from academic staff to the clinical venues. Some of the clinical teachers commented that they had not seen any academic staff when on placement while others commented that they had felt very supported this semester.

Conversely, the clinical unit of study coordinators were asking for more contact from the clinical teachers, especially when students were not performing well and were at risk of failure in the unit, for example, from August 2008, *'The main problems highlighted for first semester units was the lack of contact ... from the clinical teachers and the poor documentation on the assessment forms regarding clinical progress'* and later in this briefing session the presenting clinical unit of study coordinators

... again reinforced the need to communicate with them if there was problem students as early as possible and that they were willing to work with the clinical teachers in helping overcome issues including writing learning objectives and being present at interviews with students who are doing poorly.

In August 2007, to help overcome some of these issues, it was suggested by a clinical teacher that when a student is at risk of failure the school could adopt a process, used by some other universities, where one of the academic staff comes and works with the student for a day and then makes the final decision on a fail assessment. There are some advantages with this suggestion. However, it could also be seen as a way out of a recognised problem for clinical teachers – that of being seen as the “bad guy”, reported later in this section, as it moves the blame for failure onto somebody else. In other ways, however, there may be advantages with this suggestion. First, it would encourage communication between the clinical teacher and the unit coordinator, an ongoing issue reported above. This would help with another issue also identified in the literature (Luhanga, et al., 2008a, 2008b; Brown, et al., 2007) whereby clinical teachers state that they do not understand the process of failing a student. Involving the unit of study coordinator early is more likely to ensure the correct process is followed resulting in a fail grade being upheld.

Another recurring theme was issues around hospital where students were placed. These varied from issues with how the hospital staff related to students as in this comment, ‘*One problem that seemed common to many of the clinical teachers was dealing with the problem of when the staff (hospital) was disinterested in helping the students*’ (February 2008 report) which meant that students could miss out on the opportunities to carry out procedures or be involved with patients to the opposite problem that can affect the ability of the clinical teacher to assess the students as in this comment:

There is a view amongst some nurses, and others, about the social value of a nurse, generally that ‘a good nurse is a busy nurse’. Where this proves to be a particular problem is when students are working with nurses who hold these values and keep the student very busy. This can make it difficult for the clinical teacher to work with the student as the nurse they are buddied with keeps them so busy it is difficult for the clinical teacher to get time with the student (February 2008 report).

Many of the comments made here reflect key themes arising in the literature therefore reinforcing that the research site, the university, is similar in many ways with other clinical teachers and schools of nursing. These sessions also allow feedback from the

clinical teachers to the academics and vice versa as well as allowing collegial discussions between the clinical teachers themselves.

Educational sessions

As stated previously each workshop included educational sessions. This section will comment on the sessions held in the workshops during the data collection period. In some cases the details are only about why these sessions were held, in other cases what they produced. Table 11 outlines the workshops and the education sessions held in each. Those in italics will not be commented on as I was neither a participant nor observer due to teaching or other commitments.

These sessions were included in the data as they are a means of helping in the professional development of both novice and more experienced clinical teachers, one of the aims of the study. Within the literature review it was noted that there was an absence of depth of description given in the content of education sessions used for clinical teachers therefore this section will, to some extent, address this issue.

Table 11
Content of education sessions

| Date of workshop | Educational sessions |
|------------------|--|
| August 2007 | Racial discrimination and cultural diversity The clinical challenge process* |
| February 2008 | Professional issues and assessment* <i>General update on changes within the school</i> |
| August 2008 | Failure to fail session* <i>Report on Effective Feedback workshop</i> |
| December 2008 | <i>Introduction to simulation</i> The affective domain / professional practice* |
| April 2009 | <i>Simulation session</i> ¹ |
| September 2009 | A day in the life of a Clinical Teacher Documentation – CPAFs and the Bondy scale* |
| April 2010 | <i>Small group learning</i> The Affective Domain: Presentation, Preparedness and Interaction (repeat of a conference presentation)* |

¹ Only one education session was held in this meeting

* These sessions were developed from, and built upon, previous sessions and other data and formed the iterative part of the study.

Racial discrimination and cultural diversity

This session was arranged with staff from the Equity and Social Justice Branch of the university as there had been

... some unconfirmed reports of complaints from clinical teachers about students using this as an issue when they had been challenged by the clinical teacher; from students who felt they had been discriminated against by clinical teachers and/or clinical placement staff; and reports again from clinical teachers where they had to intervene where students from non-Anglo-Saxon backgrounds were being discriminated against by clinical placement staff. (August 2007 workshop report)

A case study prepared by the presenters was used for part of this session which generated discussion which unfortunately was limited due to time constraints that highlighted

... two major concerns for the clinical teachers. The first was the problems of poor English skills of some students that presented as poor communication and documentation skills in the clinical setting with questions about how this can be incorporated into the student's assessment, while there were comments about the graduate entry students who could not demonstrate basic nursing skills in the clinical setting. (August 2007 workshop report)

This latter issue was related to a particular course where students who already possessed a degree could enter the course at a year two without any of the nursing skills taught in the first year. This course has since been discontinued and students are granted Advanced standing in appropriate units of study if they have equivalency to units within the course.

The clinical challenge process

This was an issue that was an ongoing concern for both the clinical teachers and academic staff of the school. The clinical challenge was the process used when a student is failing to meet the requirements to pass the unit prior to a fail grade being awarded. The process has changed frequently which has caused confusion as comments in later workshops indicate that the clinical teachers still did not really understand the process. In the discussion there was a strongly expressed view that for a failing student an academic should come from the university and work with the student for a shift for the final decision to be made.

This practice was also seen to help the clinical teacher as there was a large degree of frustration felt by the clinical teachers in that if they have a student on a clinical challenge they have to work closely with that student for two days and this takes their time away from the other students who then miss out on experiences/supervision (August 2007 workshop report).

This is an ongoing concern for nursing educators as discussed in the literature, in particular the failure to fail literature and which continues to be discussed. Further comments are made throughout this thesis, from various viewpoints around this issue.

Professional issues and assessment

This session was run by another lecturer and focused on the professional domain of practice (one of the ANMC competencies (see Appendix 5)). The discussion centred on three areas, attendance, understanding of what was expected and finally professional dress. These are issues that were returned to in more depth in later workshops and will be discussed further.

Failure to fail session

Following on from the previous workshop session on professional issues it was felt that a wider discussion on the issue of failure to fail was needed. As previous sessions around this topic were all didactic in nature a different approach was taken. This approach was:

To make the clinical teachers appear to own the problems, using a more critical approach, it was decided to commence the session by asking the clinical teachers what they saw as the problems causing them to not fail students and then to discuss with them ways in which these problems may be overcome (July 2008 workshop notes).

Small group work was used to encourage the clinical teachers to identify their perception of the problem. Each group reported back to the whole workshop with the issues transcribed onto a white board. A comment made in the field notes written after the session sums up the issues identified; *‘Many of the items on the list are also found in the literature on failing to fail students although many have a more local connection with the clinical teachers giving examples from their own practice of occurrences of the events’*. Common issues identified by the groups are presented in Table 12.

Table 12**Common reasons identified in workshop groups for not failing students**

| Issues identified | Number of groups reporting this as a reason (four groups) |
|---|--|
| <i>'Short time frame'</i> ¹ | 4 |
| <i>'Don't want to be the bad guy'</i> | 3 |
| <i>'Don't understand failure process (complex)'</i> | 3 |
| <i>'Economic pressure – consumer'</i> | 2 |
| <i>'Too hard / too much work'</i> | 2 |

1. At this time most placements were of only 2 weeks duration. This has since changed to four week placements.

Issues with the short time frame and economic pressure on students can be found in the work of both the English and Canadian authors found in Table 4 while comments relating to the 'Don't want to be the bad guy' can be found in the Duffy (2003) and the Canadian works. The 'Too hard / too much work' comment cannot be specifically identified in the details in Table 4 however they are perhaps implied in comments like "Given the 'benefit of the doubt'" (Jervis and Tilki 2011).

The affective domain / professional practice

This session was introduced as follows:

At the last clinical teachers meeting one of the sessions looked at the phenomena of the failure to fail students. One of the reasons given at that time was problems with what was meant by the term affective domain and/or professional practice and what was expected from the students in this area.

Like the previous session the aim here was to have the clinical teachers think about the issue and what these terms meant for them and how they could then use this either in feedback to students or incorporate it into their assessments. Again it was an area that had been identified in the literature review as being problematic for clinical educators.

The clinical teachers present were asked to work in small groups and document their views, which were then reported back to the whole group. Table 13 presents the issues identified by more than one group.

Table 13

Affective domain / professional practice issues identified in workshop groups

| Issues identified | Number of groups identifying this as an issue (four groups) |
|--|--|
| <i>Student presentation – attitude</i> | 4 |
| <i>Student presentation – clothes</i> | 3 |
| <i>Preparation (knowledge base)</i> | 3 |
| <i>Respect for buddies</i> | 3 |
| <i>Time management – responsibility for learning</i> | 2 |
| <i>Taking responsibility</i> | 2 |
| <i>Punctuality</i> | 2 |
| <i>Confidentiality</i> | 2 |
| <i>Student presentation - coming prepared (ie with pens and a watch)</i> | 2 |
| <i>Safety aspects OH&S (take responsibility)</i> | 2 |

Again these issues are similar to those found in the literature (Brown et al. 2007 and Fitzgerald et al. 2010). Some discussion also occurred over how these issues could be addressed by clinical teachers with various ones giving suggestions as to how they handled these issues.

A day in the life of a Clinical Teacher

Given that there was going to be a reasonable number of new or novice clinical teachers at this meeting it was decided that a discussion of a “day in the life of a clinical teacher” was an appropriate topic to introduce them to clinical teaching. It should be noted that this was one of the sessions where another lecturer was ‘in control’ of the workshops and was one of the sessions which they wanted included. The clinical teachers were assigned to one of four groups and asked to address a question. ‘*Each of these four groups [had] a mixture of experienced clinical teachers with at least one, but up to three, new or novice clinical teachers*’. Each group was given one of four topics:

What are the skills and qualities needed of a good clinical teacher?

Best tips for clinical teaching

What are the key areas to prepare in approaching clinical teaching?

Outline a 'typical day' in the life of a clinical teacher

Each group was asked to write their suggestions on butcher's paper and to present these back to the whole workshop. Each group presented some very relevant issues although the group with the final question gave much briefer answers, not all related to a 'typical day'. It was noticeable that this activity did get the novice and experienced clinical teachers talking to each other and therefore would have helped build a degree of collegiality between them, an aim of the workshops, which is a function consistent with the literature.

Documentation – CPAFs and the Bondy scale

This session was designed to introduce the new clinical teachers to the documents they would be using and to refresh and reinforce their correct use to the more experienced clinical teachers. Initially attendance records, summary sheets and the formal 'At risk of failure – removal from practice' form were introduced, finally the Clinical Performance Assessment Form (CPAF). For this:

Besides going through the different sections of the form, that is the 10 ANMC competencies and the additional comments section the fact that there are two forms the students should bring with them to clinical placement, a formative and a summative version, was [presented]. It was also pointed out that the exemplars on the forms are there for guidance only and should not limit the comments the clinical teachers can make (September 2009 CT workshop).

The use of the Bondy scale was also introduced. This was partly because

it would also be used to give a grading to students through the use of a numerical grading [of] the various descriptors that can be assigned ... As this is a criterion referenced system it was important that the clinical teachers understood the descriptors that are used for each level so that they could apply them consistently (September 2009 workshop).

Two video vignettes to demonstrate two of the levels had been produced and were shown to the clinical teachers, who were asked to identify the levels depicted and what comments they might make to students.

Three out of the four groups indicated the levels that were aimed at in the videos while the fourth group ... rated the student as the lowest level on the scale. The comments made by the [three] groups were relevant to the videos ... and generally would have been helpful to a student although more detail could have been given, especially with the formative feedback comments [two groups were asked to make formative comments and two summative ones]. They were however consistent with the level of comments found on student CPAFs (September 2009 workshop).

Like many of the issues identified and used as education sessions in these workshops, the problems of understanding the use of the assessment tool and systems used to assess students are again commonly found in the literature, for example in the failure to fail literature (Duffy, 2003, Fitzgerald, et al., 2010 and Luhanga, et al., 2008a, 2008b) and are therefore an issue for many.

The Affective Domain: Presentation, Preparedness and Interaction (repeat of a conference presentation)

This was a repeat presentation of a paper given at the Leadership and Practice Development in Health: Quality and Safety through Workplace Learning conference in Hobart (Miller, 2010). It was presented partly to give feedback to those clinical teachers who had participated in the earlier workshops. The paper was developed from earlier workshops on failure to fail and the affective domain and partly to give the clinical teachers not involved the same information from those earlier workshops.

Section summary

This section has presented the content of the clinical teacher workshops conducted during the course of the study, based on the field notes made by myself after each workshop. No attempt was made at this stage to analyse the workshops. The reporting of points arising from the workshops provides a view of the focus and content presented, thus contributing insight into this form of development for clinical teachers

and thereby adds to the literature. Some of the content for the workshops was based on issues identified in the data collection as well as issues identified with clinical placements that needed addressing with clinical teachers, such as the change of the clinical assessment tool.

Clinical Performance Assessment Tool

Sample CPAFs were collected from clinical teachers who were judged as either expert or novice (more details on this are given below). One reason for this division was to see if there were differences in the approach in giving feedback to students. This may be in the amount of feedback given, the type (specific or general, only praising good points or also pointing out deficiencies) and the level of recommendations given to help the student to correct deficiencies. The reasons for this is that one could surmise that experienced clinical teachers would give specific, detailed feedback with numerous suggestions on how the student may improve their performance, while novice clinical teachers would concentrate more on tasks and problems, with less suggestions on how students could improve.

As part of the collection arrangements for the CPAFs the unit of study coordinators for the medical/surgical units of study running in the relevant semesters were asked to select samples from both novice and experienced clinical teachers. To aid the selection the unit of study coordinators were given a list of the employed clinical teachers notated to indicate who were considered novice and who ones as experts. The criteria to be met required the clinical educator to have worked with at least four previous clinical units to be considered an expert, otherwise they were deemed to be a novice clinical teacher. In some cases the clinical teachers were working in only their first or second unit for the university which is not uncommon due to the high turnover of clinical educators that occurs within nursing in Australia and other countries. The use of a time frame was considered reasonable as both Benner (1984) and Dreyfus (2004) envisage that the development from novice to expert is over a continuum, which indicates this occurring over a period of time.

Changes to the CPAFs have already been commented on. In the first group of CPAFs the summative section comprised of a short (less than half a page) section with no structure. Therefore the comments made gave very little description of how well the student was working, whereas the formative section asked the clinical teacher to give

specific details of the student's work. With the changes that occurred to the CPAF at the start of 2007 the formative and summative sections of the form were separated and students were no longer required to submit the formative section. The summative section was used in the study for these later documents. These new formative and summative forms required more comments from the clinical teachers as they were asked to comment on the ten Australian Nursing and Midwifery Council (ANMC) (2005) competencies for the registered nurse, as well to give a brief final summary. The comments section under each of the competencies was about half a page in size with only two or three lines/sentences being written in each section. Because of these changes it generally would not be reliable to compare in detail the comments between the first and subsequent batches of CPAFs and where a comparison has been made the grounds for comparison are given.

After an initial reading of the CPAFs files to gain familiarity, a coding scheme was developed. The initial coding was to separate them into those belonging to the novice and the experienced clinical teachers. This enabled further codes to be compared between the two groups. These codes were chosen as they fitted apparent areas of interest for the study. Some codes were added as further sets of CPATs were received and earlier sets returned to if appropriate. The names chosen were either taken from the data itself, as in the code Number of patients cared for, or that fitted what was being coded, as in Affective (domain). (A list of codes and their descriptors is given in Appendix 6.) All coding was done by myself. (See Table 14.) Even before coding started it was apparent that the novice clinical teachers made very brief comments, mainly stating facts, while the experienced clinical teachers made longer comments. This factor remained consistent throughout all sets of CPAFs collected. On comparison one factor stood out, that the experienced clinical teachers were more often justifying or supporting their comments rather than the one or two words used by the novice clinical teachers. The following are two examples:

1 cpaf CT3-4 Nov¹

Medication Management

versus

1 cpaf CT2-7 Exp

Observing 6-7 rights of medication administration.

¹ Nov = Novice. Exp = Experienced

Table 14 is presented to give the reader an overview of the various items coded on the different CPAFs which were collected as part of the data for this study. The significant items are then discussed in the section following the table. It can also be seen that as the CPAFs were collected over time it became apparent that it was necessary to add new codes while some codes used in previous data sets were no longer noted.

No percentages are given due to the low numbers in some cases while the intention is to focus on the items coded rather than the numbers of such item unless this is thought significant and are therefore discussed.

Table 14

Number of comments made by novice and experienced clinical teachers on students CPAFs

| | First CPAF set | | Second CPAF set | | Third CPAF set | | Fourth CPAF set | |
|--|----------------|-------------|-----------------|-------------|----------------|-------------|-----------------|------------|
| | Novice | Experienced | Novice | Experienced | Novice | Experienced | Novice | Experience |
| Ticked item | | | 5 | 2 | 0 | 4 | | |
| Comments with justification | 0 | 6 | 0 | 1 | | | | |
| Comments with explanation | 2 | 15 | 8 | 15 | 5 | 15 | 5 | 11 |
| Comments without support | 11 | 0 | 9 | 10 | 0 | 4 | 7 | 5 |
| Supportive | 0 | 4 | 9 | 13 | 5 | 9 | 17 | 6 |
| Learning dirrection | 12 | 14 | 4 | 2 | 1 | 5 | 4 | 3 |
| Negative comments | 0 | 2 | 1 | 0 | 1 | 1 | 0 | 1 |
| Medication | 6 | 10 | 8 | 13 | 0 | 6 | 10 | 16 |
| Tasks | 0 | 1 | 2 | 1 | | | | |
| Clinical skills | 2 | 8 | 3 | 7 | 4 | 8 | 16 | 12 |
| Care planning | 8 | 9 | 14 | 16 | 6 | 15 | 16 | 15 |
| Communication skills | 2 | 10 | 13 | 15 | 6 | 12 | 15 | 13 |
| Assessment skills | 4 | 7 | 12 | 16 | 4 | 10 | 15 | 14 |
| Scope of practice | 1 | 4 | 11 | 12 | 4 | 5 | 13 | 14 |
| IV therapy | 3 | 5 | 0 | 5 | 0 | 4 | 2 | 6 |
| Wound management | 1 | 0 | 1 | 7 | 0 | 3 | 3 | 6 |
| Admission and discharge | 2 | 0 | 3 | 7 | 2 | 6 | 4 | 5 |
| Handover | 1 | 0 | 0 | 7 | 4 | 3 | 7 | 5 |
| Teamwork | 0 | 3 | 11 | 15 | 3 | 14 | 11 | 15 |
| Technical skills - not specified elsewhere | | | 2 | 4 | 4 | 5 | 3 | 6 |
| Hygiene care | | | 0 | 2 | | | 0 | 4 |
| Documentation | | | 10 | 14 | 3 | 11 | 10 | 11 |
| Evidence-based practice | | | | | 3 | 2 | 9 | 3 |
| Regulatory aspects | | | | | 3 | 7 | 0 | 3 |
| Time management | | | | | | | 6 | 9 |
| Number of pts cared for | | | | | | | 3 | 6 |
| Psychomotor | 12 | 12 | 7 | 15 | 2 | 8 | 5 | 9 |
| Cognitive | 13 | 16 | 14 | 16 | 2 | 4 | 7 | 13 |
| Affective | 12 | 15 | 15 | 16 | 6 | 13 | 17 | 16 |
| Comments different from performance criteria | | | | | | | 2 | 0 |
| Total CPAF's | 10 | 15 | 16 | 16 | 6 | 15 | 17 | 16 |

Learning direction

One thing that is noticeable about the later sets of CPAFs is the low amount of learning direction that is being given to the students as compared to the first collection of CPAFs. It needs to be recognised that these are summative documents, not formative, but that should not exclude the clinical teachers from providing the student with some learning direction, in particular given that the students will have at least two more clinical placements after completing the units used in the study. The following table sets out the differences in the number of comments recorded under the heading of learning direction between the sets of CPAFs.

Table 15
Learning direction comments

| | Year/semester | Novice | Expert |
|--------------------------|---------------|--------|--------|
| 1 st CPAF set | 2007/2 | 12 | 14 |
| 2 nd CPAF set | 2008/1 | 4 | 2 |
| 3 rd CPAF set | 2008/2 | 1* | 5 |
| 4 th CPAF set | 2009/1 | 4 | 3 |

* this number may be artificially low as only 5 CPAFs were received for novice clinical teachers for this group.

It should also be noted that the novice comments in the second group of CPAFs were made by only one out of four clinical teachers, the four in the above table being for four different students. Of the expert clinical teachers there were two out of three clinical teachers making comments about one student each.

The difference between the first and following sets of CPAFs may be due to changes in the form used by the university. In the first set of CPAFs the clinical teacher was specifically asked to make comments on 'Strategies for Development' whereas there is no such section or request on the forms used in the subsequent groups of CPAFs. A second reason is that with the first group the formative section was available, while with the subsequent groups it was only the students' summative document. This should not make a significant difference as the students have not finished their course so will still have further clinical placements to complete. It would therefore seem to be useful to them if they were given some guidance as

to how they could improve their future clinical practice as well as giving them an indication of what they are doing well. It may also be that the clinical teachers feel that these comments belong more to the formative assessment document rather than the summative document or in the verbal component of the summative assessment, something that was explored in the clinical teacher interviews and reported later in this chapter.

Comments without support

It was noticeable that the number of items coded as ‘comments without support’ were much reduced in the third round of data collection and did not increase significantly in the fourth round CPAFs. Whether this was related to a variation in coding or if there was an actual change cannot be said for certain. However as the other comment codes are not significantly changed it could be accepted that there has not been any major change in coding technique.

Table 16
Comments without support

| | Year/semester | Novice | Expert |
|--------------------------|---------------|--------|--------|
| 1 st CPAF set | 2007/2 | 11 | 0 |
| 2 nd CPAF set | 2008/1 | 9 | 10 |
| 3 rd CPAF set | 2008/2 | 0* | 4 |
| 4 th CPAF set | 2009/1 | 7 | 5 |

* this number may be artificially low as only 5 CPAFs were received for novice clinical teachers for this group.

If this trend continues this can be seen as positive as it means students would be provided with the reasons for the comments made by the clinical teachers. In this way the students are given some direction in both their learning needs and where they are doing well. For example some clinical teachers have commented on the level students are achieving the competencies “*Achieved above competencies to an acceptable standard*” (3 cpaf CT1-2 Exp) and gave more general comments such as “*Researches literature to support her nursing interventions and always explaining interventions to her patients*” (3 cpaf CT5-1 Exp).

It also became apparent as further sets of CPAFs were collected that each clinical teacher has a particular style of writing for their comments. It was possible in many cases to identify the same clinical teacher between the different collections of CPAFs through this (even though the documents were de-identified). A reason may be that experienced clinical teachers have developed a repertoire of stock phrases to use when writing about students' progress whereas the novice clinical teachers have not, so they fall back on the examples they have in front of them, the CPAF document. This does limit the feedback given to the student, as it is the same, or at least very similar, to the document. When it is not copied there is often further information given in the comments, as for example in the following comment from an experienced clinical teacher.

Performance criteria ... - *Seeks out opportunities to meet objectives*

Comments ... - **** has taken every opportunity to meet his objectives as he is extremely keen to practice and develop his nursing skills (2 cpaf CT2-1 Exp).*

The CPAF forms ask the clinical teachers to make "Comment to explain ratings, and provide exemplars of practice". These performance criteria did act as cues for the clinical teachers in making their comments about the students for both the novice and experienced clinical teachers. The way that the comments followed the performance criteria does vary between the different clinical teachers. In some cases the comments are almost word for word the same as in the performance criteria while in others it is very much the clinical teachers own words being used. It was more likely though to see the wording being the same as the performance criteria with the novice clinical teachers than with the experienced clinical teachers.

Feedback to the student is important in whatever form as this can help the student understand the areas they are working well in and those where they need to improve. There is also the view that written feedback is better than oral feedback, therefore any written comments will reinforce the verbal feedback that the clinical educators give to students (Gigante, et al., 2011 and Sherwin & Muir, 2011).

The audience

This was not a code used in the analysis, rather a comment on something noted. Reading these CPAFs as an ‘outsider’ it is very difficult, if not impossible in many cases to get any real sense of what each student is like as there is very little specific information given about them. As these documents are used by the Clinical Unit of Study coordinator to assign a grade (either pass or fail at the time of this research) it would seem to be very difficult to do so given the information written on the form. It would seem to have to be a case that if there are no negative comments the student will pass.

A second group of people who may be reading these comments are Graduate Year Coordinators from hospitals. The CPAFs can be used by the student for Graduate Year applications. Again the problem here is the lack of detailed information for the Graduate Year coordinators to make an assessment of the student, something commented on in more depth later in the discussion of the clinical teacher interviews.

A further group are the students themselves, but what they can get out of them as there is little, if any, learning direction in them again is problematic as already discussed. This may not be the case though as this type of information may be given to the student verbally as part of the discussions that take place in the final interview with the student when they are given the copy of the form to take back to the University.

Another point related to this is noted in the writing of one clinical teacher. The clinical teacher gives a lot of information about what they are doing with the students as though they are saying “look, I am fulfilling my role”; for example this section from a CPAF *“Handouts provided and discussion in debriefing sessions in regards to commonly prescribed medications and disease processes has aimed at assisting in further development of overall knowledge base”* (2 cpaf CT1 (Exp)-1). This comment can also help with the reader gaining an understanding the student’s level of achievement as it gives information about possible gaps in the students’ knowledge as well as what the student should, and in other examples does, know. Although it is not explicitly stated in the above comments or elsewhere in this section, it can possibly be inferred that the student needed further development in this area.

This is something that was explored further with the clinical teachers in their interviews.

Comments and the learning domains

The sets of CPAFs collected were coded for comments relating to the three learning domains, psychomotor, cognitive and affective. There is generally consistency in the number of comments coded as such across the sets of CPAFs collected except for two areas. The first is that the number of comments dropped from the first to subsequent sets of CPAFs, which may have been due to the lack of formative comments, while the second is generally low number of comments for the third set of CPAFs collected. No particular reason has been identified as to why this occurred.

When cross referencing the domains against nursing actions they map quite well to those expected, as can be seen in Table 17. In this table the numbers of items coded as both a learning domain item and a skill have been cross tabulated to show the number of items coded as both. This is important as different skills will use different learning domains more than others. For example, medication management involves both a psychomotor skill in being able to manipulate tablets and syringes when giving injections; *“### carries out technical procedures and safely ie; supervised administering subcutaneous Clexane and Heparin competently, whilst promptly disposing of sharps.”* (1 cpaf CT3 (Exp)-1) while the nurse also requires cognitive skills in knowing about the medications they are about to give, whether they are appropriate for the patient at this time, are there any side effects showing and are they likely to interact with other medications are examples of this aspect as seen here; *“Knowledge base in regards to commonly prescribed medications has notably improved. On review of medication charts with her Educator, ### is developing the ability to relate pharmacology to disease processes. Common side-effects have also been considered”* (1 cpaf CT3 (Exp)-6).

Table 17
Learning domains cross referenced with skills

| | Medication | Clinical skills | Communication skills | Care planning | IV therapy |
|-------------|------------|--------------------|-------------------------|------------------|---------------|
| Psychomotor | 13 | 9 | 0 | 3 | 7 |
| Cognitive | 17 | 4 | 1 | 17 | 2 |
| Affective | 1 | 1 | 11 | 4 | 0 |

Communication skills should and do map mainly to the affective domain. Care planning is an example where all three domains are used with an emphasis on cognitive action by the nurse as can be seen by the high number of references to this. Cognitive actions are need in putting facts known about the patient, their medical condition and where they may be on an illness trajectory together to plan care. The other domains are found in interacting with the patient to gather information psychomotor skills are needed to carry out assessments for some information while affective skills are also needed to effectively communicate with the patient/client so all three domains in this area would not be unusual.

Section summary

The review of the CPATs has been discussed in this section with a focus on the key aspects of these documents. Discussion on the amount and type of feedback given in them to students has been made as this is an important aspect of these documents. In the first set of CPATs collected there were quite a few comments noted that gave direction for the students learning. This may partly be due to the fact that these first CPATs contained a formative section, something that was not available to the research in the later ones. Supporting information was more predominant in the earlier CPATs collected however this did increase with the later CPATs collected. This information is helpful to students as it can give them an indication about their skill levels. Analysis of the comments made showed that latter CPATs were providing direction for the students' learning. Despite this it was also noted that many of the comments on the CPATs would not be that useful to another person reading them in gaining a clear idea of the level the student had reached during the placement. Comments made were also coded to the three learning domains to see if there

was a focus on clinical skills (psychomotor skills) as suggested in some of the literature. This was not found to be the case.

The Clinical Teachers – Initial interviews

The clinical teachers who took part in this study were a convenience sample of those employed by the School of Nursing where the study took place. Recruitment occurred in two ways, the first by a presentation during a clinical teacher’s workshop to those present, and to follow up on this and also invite those not present, by an e-mail sent to all employed clinical teachers by the Clinical Learning Office outlining the study and inviting participation. Five participants were recruited in this way; the sixth was not employed at this time and was given the invite by the academic who oversaw clinical learning within the school at the time. The number of participants was approximately one fifth of the clinical teachers employed by the school at that time.

Background and qualifications

The following table sets out information on the experience of the clinical teachers who participated in this study.

Table 10
Data collected according to source Table 18
Experience of participants

| Teacher | Length of experience as a clinical teacher | Qualifications held | Relevant experiences noted |
|---------|--|---|---|
| CT1 | Less than 2 years (second experience) | | A preceptor in the hospital system |
| CT2 | Less than 2 years (fourth experience) | Certificate IV in Workplace Training and Assessment | A preceptor in the hospital system |
| CT3 | 7 years | Masters degree in an area of nursing specialisation | A preceptor in the hospital system |
| CT4 | Less than 2 years (second experience) | | A preceptor in the hospital system and ‘ <i>done a little bit of medical education, like junior doctors ...</i> ’ (CT4 1 st interview) |
| CT5 | Less than 1 years (first experience) | | Previously worked as a teacher |

| | | | |
|-----|--------------|---|---|
| CT6 | Over 10Years | Certificate IV in Workplace Training and Assessment | Clinically supervised enrolled nurse students |
|-----|--------------|---|---|

Those with less than 2 years/four experiences as a clinical teacher were counted as being novices for the purpose of these interviews.

The role of the clinical teacher

Five out of the six participants indicated that they had no or very little preparation for the role. Some of these clinical teachers had experience as preceptors and viewed this as a form of preparation for clinical teaching. Three had attended a session at the university prior to first working in the role although they did not find these sessions were useful. Some of the participants did discuss what they did find useful, or what they thought would have been useful to them. One participant talked about *'it took me at least two years to get my head around ... [the role] because you know every time [I asked] what could I have done better, what could I have done better'* (CT3 1st interview). This participant also said *'if I had training ... in adult teaching I think I would have been a little bit better prepared'* (CT3 1st interview).

The following quote from one participant sums up the general view about their role; *'I am their preceptor I am their mentor, I am also a role model for them'* (CT5 1st interview).

Two roles were discussed in depth by the participants these were facilitation and support. There were two forms of facilitation described. The first of these is that the clinical teacher is there to facilitate the students learning and that in fact teaching is done at the university: *'I believe that the teaching is done at the university, and then when we get them, we facilitate their learning in order for them to apply what they've been taught already'* (CT3 1st interview). This part of facilitation is about getting the student to understand and relate their theoretical learning and knowledge to the clinical setting to help them develop into appropriately skilled nurses. The second form of facilitation mentioned is around communication with the clinical venue staff for opportunities for the students to practice and develop their skills. It could, in this role, be said that the clinical teacher is facilitating the learning environment for the student/s. It was put this way by one clinical teacher *'making sure they get ... the optimum out of their clinical experience while they're there'* (CT3 1st interview).

The term support was also used by some participants in their responses. In some cases it was used in the same way that some of the other participants used the facilitation role, to support the student to develop. One participant talked about it as '*somebody, they can come to when they have problems*' (CT5 1st interview) indicating a more psychosocial support person rather than necessarily with only clinical or learning issues.

Challenges of the clinical teacher role

Lack of information and lack of support were raised as issues by some of the participants. The lack of information came from both novice and experienced clinical teachers; however the issues tended to be different. For the novice participants the requirement for information was more around knowing what was expected of them, what the students could do and knowing the universities processes. These relate to a lack of adequate preparation for being a clinical teacher and although they are required to attend a clinical teachers' workshop before going on their first clinical placement some did not for various reasons. For the experienced participants it was more about changes of policy and how they were supposed to deal with student issues in a new and changed way. All clinical teachers are supplied with an updated clinical handbook at the start of each year which contains this information, which they can use as a reference later or if unable to attend the clinical teachers' workshop. Additionally, one clinical teacher commented on a lack of support from the academics at the university. This participant described situations where a need arose to discuss student issues with an academic, but no academic staff member was available. This was an ongoing issue that was also raised in some of the clinical teacher workshops and noted in that section of this chapter.

A requirement of the Nurses Board of Victoria (NBV) (2008) is that a clinical teacher supervises no more than 8 students. Students are not all in one area and can be spread over several areas in a venue. Comments were made by the participants that at times this meant that they were spread quite thinly in how they could allocate their time to each student. In some cases two students in two separate areas were undertaking work that required the clinical teacher's presence but it was impossible to be in both places, which then becomes an equity issue. Being required to assess a student in a two week placement compounded this problem. In particular this was an issue when the clinical teacher had a failing student

who required more of their time. This meant that the other students had less time with their clinical teacher. Venue staff might also question where the clinical teacher is, not realising there are occupied in another ward or area.

Clinical venues and working with the staff

Communication with the clinical venue staff is seen as being very important, but there can be difficulties. Setting up good communication was also seen as being hard work. However, it was worthwhile if the clinical teacher was able to achieve this. As one participant said '*I think it is extremely important ... to communicate with the staff because they're your eyes and ears when you're not there*' (CT2 1st interview) yet others report difficulties with this, for example '*we were there for two weeks, and it took me - eight days before I could actually get in contact with the nurse unit manager*' (CT4 1st interview). Being able to get on with the ward staff was seen as important '*because if you are clashing with the staff then they don't have that much support for the students and then the students will suffer*' (CT5 1st interview). Showing appreciation for communication about the students was also seen as important as this encouraged further feedback. Feedback can be problematic, through. One of the participants made the following comment; '*I find ... occasionally ... that some of the feedback is mischievous and you find that it's mischievous because they don't get on well [with the student], so you got to be able to judge that*' (CT1 1st interview). In some ways this may be worse than no feedback at all so therefore the clinical teacher has to be able to make their own assessment eventually.

Making things easier for the students and enabling them to acquire experience were also mentioned by the participants in their comments about venue staff; '*because [if] I'm not there it's up to the ward then ... to ... implicate them [students] in doing [activities on the ward]*' (CT2 1st interview). Another participant also mentioned that they encourage the students to ask questions of the venue nurses as they are the experts on their particular area whereas the clinical teacher is more likely to have only general knowledge of the area. This also shows respect for the venue staff and their knowledge, thus making it more likely they will be willing to share information or activities. There is a connection here with the facilitation role mentioned earlier as by forming and having a good relationship with the ward staff it is likely to make that facilitation easier.

Student issues

The participants were asked to discuss the sort of problems/issues they encountered with students. This brought a wide range of answers ranging from personal issues with students to knowledge deficits and interactional problems in the clinical setting. A major problem was the lack of understanding of the role of the nurse in the clinical setting. That there is a lot of basic work carried out by nurses, "*I didn't do three years of nursing to wash people*" (CT1 1st interview) is how one participant put it. This was linked to the image of a nurse portrayed in television shows where the unglamorous side of nursing is not shown. This clinical teacher also talked about students being reluctant to look after old people, again something that was linked back to the image presented by television shows. Another issue raised of this type concerned students who only wanted to work with one type of patient or client. For example this participant repeated a comment from one student; "*I only came in to do paediatrics, babies, and they're hiding from showers, running away*" (CT1 1st interview); so again there is a misconception about the nature of nursing. Other participants talked about the students not having any idea of the concept of shift work, team work and the patient load they will be expected to take on graduation.

Two participants talked about the clinical setting being a strange or foreign environment for the students. The outcome of this was that they would want to stay together and/or were reluctant to put themselves forward and thus potentially missed out on opportunities to be involved. One talked about uniforms and the fact that it caused them to be "*sticking out, they feel a bit, conspicuous as it were*" (CT1 1st interview). Other points that were mentioned included issues around lateness and absenteeism and a lack of skills. The participants were asked how they then dealt with these. In reply there was a sense that the participants used different approaches depending on the problem which is what one participant said; "*... there's not one big thing I actually individualise it, depending on the students needs*" (CT3 1st interview). Communication with the student was a technique that was mentioned. This though took several forms; in some cases telling the students what was expected or giving them clear feedback on issues if they were not making the grade to pass, through to discussions to find out what issues the student may have if there are problems on placement and creating a relaxed atmosphere so that can happen. Two participants indicated that they take a strong stance with students and issues, one saying

that they tell their students quite bluntly what is expected and what to expect while the other commented on using the placement institutions policy and procedure documents to show how students are expected to act. The other participants did not mention the type of stance they might take with students although one other did use words like “*straight away*” and “*highlight the issues immediately*” (CT4 1st interview) which gives the sense that they would be very firm with students.

Two other aspects were mentioned, the first was making use of the academic staff (the Unit of Study coordinator) as somebody appropriate to discuss issues with. The participant gave an example where they did this on one placement with a particular student issue. The second concerned working directly with students particularly when the student is having issues. Again examples were given; one where the student was so nervous when the clinical teacher was present that it was affecting the student’s performance, and that they left the student with the buddy nurse and then got feedback from that nurse at the end of the shift. With another student they stated “*I put on all my gear [dressed like a clinical nurse] and I spent the first four hours of the shift with her*” (CT3 1st interview).

Things that help in the role

In response to a question about what helped them in their role a variety of different experiences were discussed. First was clinical experience, almost all of the participants mentioned this in some way, sometimes linking it to other types of experiences in particular working in a clinical venue and also having students in that venue. Being known by the clinical venue staff also had benefit for the clinical teacher and the students. Being experienced was seen as a barrier by one participant who had the view that because they were experienced they may have forgotten how the student may be feeling when approaching a new task or procedure. Other forms of experience were also seen as being helpful. One talked about the preparation they had received for being a preceptor as being helpful in their role as a clinical teacher while others drew on personal experience or experiences gained in other employment, an example of this is the clinical teacher who had been a teacher before coming to nursing.

Hindrances in the role

The participants talked more about issues that hindered them in their role than things that helped in the role. Dealing with clinical staff as discussed above was one issue raised. Two other issues were where the participant, in discussing the students being used as “*cheap labour*” (CT2 1st interview) commented that they had to stay on a ward once for the shift as if they did not there was no one to supervise the students there as degree students need to be supervised by a Registered (Division 1) nurse. Students who are Enrolled (Division 2) nurses can also be affected by this in that if this is recognised by the clinical staff they can be encouraged to fulfil that role, that of the Enrolled (Division 2) nurse, which can put them outside of the scope of practice of a student thus creating legal and registration issues. The other issue is being able to arrange an orientation with a venue if the clinical teacher has not been there before. This is sometimes made worse when there are apparent communication failures at the venues and the clinical teacher is greeted with “oh I didn't know you were coming” or “I didn't know we were having students”; this can make one wonder what sort of reception the students receive when going to such placements.

Time has already been referred to as an issue for some clinical teachers. Having sufficient time to complete the assessment forms was also raised “*it's not time allocated for yourself to do your assessments and stuff like that its time allocated to be spent with students*” (CT4 1st interview) is the way one participant phrased this. This was supported by another participant who said that they took the appraisal forms home to do as they wanted to spend their time at the clinical venue with students. Another participant discussed some of the processes that are in place to deal with problem students as being time consuming thus taking them away for their other students as another issue which has already been mentioned.

Finally there were issues around what can be called ‘the reluctant student’. Some can be good at avoiding or hiding from the clinical teacher while others are good at “*faking it*” (CT1 1st interview) for example saying that they have done something when in fact they have not. The participant who discussed this also commented that sometimes the clinical venue staff can collaborate in this deception as the clinical teacher cannot be there to see everything. Sometimes students will say that they cannot do certain tasks and when

questioned *“they turn around and say to you “but we haven’t done that at university” you take that as gospel, ... it’s only my role here now that I realise that they’re telling me fibs”* (CT2 1st interview). At the time of this interview the participant was also doing laboratory teaching, so they were aware of what students had been taught prior to the clinical placement. From this it can be seen that some students can be *“quite manipulative”* (CT2 2nd interview), a problem for the new clinical teacher if they are not aware of this.

Clinical Performance Assessment Forms

Other comments have been made about these forms in the earlier section and the comments here are additional ones made in the interviews that are not reflected in that section. Questions on the CPAFs were included as they are the main feedback to the student and the university about the students’ performance from the clinical teacher. A comment made by several of the participants was that they found them repetitive, often writing the same comments for different sections as well with one participant noting this occurring between the formative and summative forms, something that was also noted in the review of the forms. It was felt that it was only in the summary section that they could give an individual view of the student. The use of two forms was generally seen as a positive move as *“it gives the teachers and the students an opportunity to bring everything out in the open”* (CT2 1st interview) as the formative document is for the student only and so the comments made are not seen by anybody else, unlike the earlier forms where both the formative and summative assessments were on the same document; important as the assessment forms are used by hospitals as part of the selection criteria for graduate year places.

The Bondy scale

As part of the questions around the Clinical Performance Assessment Forms (CPAFs) the participants were asked about the use of the Bondy scale. The Bondy scale was developed in the early 1980’s by an American nurse academic as a criterion referenced rating scale that could be used in assessment of nursing students’ clinical practice (Bondy, 1983). It is now used extensively in nursing education; for example one participant commented *“I’ve only ever assessed nurses using the Bondy scale, and that was here and in the UK as well”* (CT4 1st interview).

The responses to this question were either quite detailed showing that the participant had a good understanding of its use to only very vague answers that suggested that the participant did not really understand the scale at all. There were also responses made that suggest that students do not understand the scale either, mainly around expectations that they will get a high grading all the time whereas it relates to their current level and scope of practice. It was said that when the clinical teacher points out why they have been given the grade they have rather than the one they were expecting the student can see why that is the case.

Although the Bondy scale is a criterion referenced scale one participant thought that it was very subjective; *“because what I think deserves a four another teacher will think deserves a five, or what I think deserves a three someone else will think deserves a two”* (CT3 1st interview). This may be partly because the clinical teachers have problems deciding on where to place the student; for example *“it's very difficult to place them into that particular category, because they might be that category on, on a part of their skills and that category in another part of their skills, ... some areas they're excellent in and other areas they really really [sic] need to work on”* (CT2 1st interview). Experience in using the scale would seem to help in its use as the participant later added *“the more you use it the more user friendly it becomes”* (CT2 1st interview). One effect of the use of clinical teacher workshops could help in this area in that as the clinical teachers come together into a community of practice they could be discussing how they rate students using this scale and therefore will form a consensus view on how to rate students as outlined in the next section.

Clinical teacher workshops

One factor that comes out very strongly from the participants was the use of the workshops for networking purposes as one of the participants noted:

... it provides an opportunity for the clinical teachers to meet, and possibly just informally to discuss issues that they have had and, and I suppose brain storm a few things as well [Interviewer: anything else] I think you feel a little bit supported too by realising that you're not the only one that has that problem and that it is a general problem, and it's not you, I think (CT4 1st interview).

This networking and support not only happens at the workshops but outside as well; another participant said that through meeting another clinical teacher at a workshop and exchanging contact details, when they later had a problem they were able to contact her and discuss the situation to bring about a resolution.

Two of the novice participants responded that they did not find the workshops to be useful. One then did further clarify their comments saying that some aspects were useful but suggested content that should be included, although this would only be useful for new clinical teachers, not the experienced ones. The second participant commented on the language that was being used in the workshop, finding the abbreviations and academic talk being quite different to that used in the clinical field. Thus, rather than being helpful to new clinical teachers they may in fact act as a barrier to them. Several comments were made about what content was found useful and what could be included in the workshops, some for specific questions and others just given in the conversations. One negative note raised by one participant was when they said “*I think sometimes the workshops are used as a bit of a ... complaining table, sort of a bit of a whinge bowl*” (CT4 1st interview) and favored the workshops to be more around educational sessions for the participants.

The Clinical Teachers – Second interviews

The second round of clinical teacher interviews was held to seek clarification of points and issues that had been found in the earlier data collections. As such the questions were more targeted. Like the earlier interviews they are reported under the headings the coding clustered to rather than the questions asked although in some cases these are the same.

Giving feedback to students

From earlier analysis, in particular that around the assessment forms, the type and style of feedback given to the students was an important issue to explore further. One clinical teacher made this comment when asked about the difference between written and verbal feedback:

I actually give a reasonably good overall view of not so much what they done but how they done, the manner they done it in, and ... I don't always write it I usually sit down and talk to them and give

them ... encouragement and say what they could do in the future.
(CT1 2nd interview)

It is quite clear that much of this is done verbally; this comment about formative assessment feedback was made by another of the clinical teachers:

I discuss those aspects of that domain and how do you think you are going in that one, you know what do you think we can do, and I actually put the onus back on them, what do you think you can do, or how can I help you do it, so I don't actually set formal objectives for them but I do say to them you know this is what you need to go and do. (CT2 2nd interview)

This is a problematic issue, identified by students themselves as commented on in the section on the student focus groups and in academic works. This will be discussed in depth in the next chapter as if the student is not clear about what areas they need to improve in they are less likely to work on developing in these.

One of the clinical teachers was aware of the effect that what they wrote could have on students and their future employment, commenting that:

I tend to look at the formative and summative assessments particularly in third year as a very very very [sic] critical piece of information that the perspective employer is going to look at, and if you put negative or derogatory comments on there I think that might impinge on the student, so I definitely don't tend to put negative comments on there ... (CT2 2nd interview)

Another of the participants who had taken up a hospital role since the first interviews made this comment from the other side of the fence:

I think that honestly with those appraisals because I read them now, minimal information on the appraisals that you can go off in terms of how does the student actually perform, you've told me a little bit about them but you haven't mentioned anything about communication, anything about teamwork, anything about all of

those professional issues that an employee may be interested in, ... you've got all of these ticks but you've got no supporting or clarifying statements, so do we hold much weight with them, no we don't because there's no supporting statements, no clarifying evidence, if you give me a tick and you haven't given me anything else, so I can't tell how this student actually performs in that environment you've assessed them in, so that I think we under use those tools quite a lot (CT4 2nd interview).

These comments reinforce the view given in the section on the CPAT forms where comments were made about the lack of information that can be gained by a reader from some of these forms.

Managing people

The management of people was raised as an issue:

they use the clinical teachers as the vehicle to deal with any of those issues whether it be professional development issues or whether it be personal issues and quite often you do have to deal with personal issues and that's a very hidden thing, that's not just confined to undergraduate its confined to just managing people in general, and I think that's something that we haven't had to deal with much before but recently it rears its head quite often. (CT4 2nd interview)

The clinical teacher went on to talk about acting as a counselor as another role in managing people.

Communication skills are important skills for any clinical teacher to use in their many roles as part of their managing people skills. Clinical teachers need to be firm, even assertive at times, with students and in some cases the clinical venue staff; for example, “*sometimes you need to get firm with them [students] and you have to be able to be, to do that in a positive, in a positive way as opposed to just saying, you know you're bloody hopeless*” (CT2 2nd interview) and from another clinical teacher who commented about the need to be

“assertive, not aggressive but you do have to be assertive, you have to stand up for yours[elf] and your students” (CT6 2nd interview).

The relationship between the clinical setting and university has to be made clear:

doing is very different to the universities perceptions of what the students should be doing, and I must admit that was a battle a lot of the time, but it was just about clear communication lines and reiterating to, at the end of the day ... the students are accountable to the university, and that's why they're here on the clinical placement, to meet the objectives set by the university, not to meet the objectives that are set by the nurses on the unit, and I often did have that difficulty, once I clarified it and say it in a very diplomatic way everybody seems to come on board, because at the end of the day we're not here to create a work force for the hospital. (CT4 2nd interview)

There are two clear and distinct issues here. The first is dealing with students and their issues which may be academic, their learning needs, and also their personal issues that they may bring to the placement or which has an effect on their practice on placement. The second is working with the clinical venue staff to get the best for the students placed there, the facilitation role mentioned in the next section.

Development as a clinical teacher

All four participants reported undertaking some development by reading and updating their knowledge or going to education sessions in areas they felt they needed support and or development. One example of this is the following comment made by one of the clinical teachers where they were talking about things they needed to do which included being able to “articulate to the students like a disease process or clarify it or break it down to a point where it's understandable for them, so you have to go home and you have to do a lot of research, to keep your own practice or your own knowledge current” (CT2 2nd interview).

Only two mentioned the clinical teacher workshops as a source of development for themselves. One clinical teacher saw this as being very useful; “it puts a face to the people

behind ... the people you speak to on the phone” (CT2 2nd interview), the people you deal with at the university.

The participants were asked about how new clinical teachers could prepare themselves to step into this new role. First there needs to be a realization of what the role entails, described by one participant as this:

the role itself entails like you have to wear quite a number of hats, one being educator, one being facilitator to the units that actually, you are actually walking in, communications skills need to be exceptionally good, you need to have a good solid foundation in your own ... practice, and probably a broad knowledge of other areas or willing to learn about other areas, and you have to be I suppose sometimes guidance for the students. (CT2 2nd interview)

Another just commented on the facilitator role where they said “*basically you’re like a facilitator, actually helping them put their clinical knowledge into practice with your patients*” (CT2 2nd interview). One danger is that the clinical teacher can be too “soft” on the students, acting in a mothering role. However the experienced clinical teachers realise this and commented this way to a question about this aspect:

I think that is inherent in the role but I think you just need mother in you, you know a lot of these students, but particularly the younger ones, need, need to I suppose break the apron strings and I think you need to facility that role of breaking the apron strings and saying, no I’m not here to do for you. (CT2 2nd interview)

To become a clinical teacher the following advice was given by another participant:

they may already have qualifications and skills and experience but I think everybody needs to have a refresher on how to teach clinical skills, because we teach clinical skills very differently and it, I don’t even think we think about the process ... feedback is also very important thing, our students often don’t think they’re getting feedback because it’s given in an informal situation or its given on

the run, so I think we need to, we don't need to formally give feedback but we need to make students recognise they're getting feedback ... [and] how to write appraisals, I think the appraisal process is very important because that's basically what, what's held on to, what goes on record (CT4 2nd interview).

The participants were asked if they thought knowing what the students had been taught in the linked theory unit would be helpful with all agreeing that it could, however it was not imperative, as put by this comment:

I think it's relevant because of course you have to consolidate the theory that somebody has just been involved with so you can address that you can give them patients that have had those conditions that you've just looked at but at the end of the day you're going to take on any learning opportunity that you can and you're going to try and relate it to context that you're in (CT4 2nd interview).

Overall there has been some useful advice given by the clinical teachers in their interviews here which could be written up and presented to new clinical teachers in future workshops or used as handouts to them as part of the orientation packages.

Section summary

Two interviews were held with the clinical teacher participants in the study. The first at the start to gain initial data from them, and a second at the end of data collection, to gain more depth to issues that were thought important to the study but which lacked data. Most of the participants had been preceptors prior to becoming clinical teachers and was viewed as an important part of their preparation for the role. A facilitation role for the clinical teacher was initially identified in the first data collection and kept on being returned to at times. Good communication skills was another skill that was identified as being important and used in many aspects of the role, in dealing with students and venue staff. For some participants the CPAFs were problematic, requiring time to write them up, however the participants also recognised that they could be repetitive in what was documented on them.

What was more of a concern was some of the comments about the use of the Bondy scale and the potential for inconsistency in its application to different student groups. The clinical teacher workshops were commented on and were seen mainly as a venue for meeting and talking with other clinical teacher, what could be considered as helping to develop a community of practice, a role for these workshops that was suggested in the literature (Hodkinson, & Hodkinson. 2004). Such communities of practice could also help overcome some of the issues identified with the use of the Bondy scale.

In the second interviews three main areas were discussed. The first was the giving of feedback to students. This was flagged as a problematic area in the in the review of the CPATs and followed up further here. All participants indicated that they gave good verbal feedback and acknowledged that there could be problems for students if they wrote about poor performance on the CPATs in gaining graduate year positions. The second was about communication skills and the various use of these. Working with students to resolve learning issues with them was one area identified while working with venue staff was the other, again adding and aiding the facilitation role. The third was about development, in particular what would help new clinical teachers. The responses were more around what the role entails, as if the new clinical teacher has an understanding of this they can then prepare in those areas.

Student focus groups

There were three third year and two second year focus groups held. It was noted during the transcription the issues raised by the students were very similar therefore although the second year groups were only on their second or third clinical placement whereas the third year student would have been on their eighth or ninth clinical placement their experiences did appear to be comparable.

The questions may appear to be quite similar in nature; however they were designed to elicit different information that may not have come out with only one question. This was in fact the case with an overall broad response being obtained in this manner. The following are the responses from the students clustered as they were sorted in the initial analysis of the transcripts, in some cases as the questions asked.

Students views on the role of the Clinical Teacher

The role of the clinical teacher was to be there as support, found in all of the focus groups. Support though was used in various ways; support as guidance; support as in support a student in case of problems; described as *“be like an advocate”* (FG3 2nd year) and support in being there to answer questions. Support was also expressed in other ways; one student commented *“guide them in like their learning”* (FG2 3rd year) although this could also be thought of as teaching. Support was also linked to the following comment from another focus group *“help you through that transition of being a student to a nurse”* (FG4 3rd year).

Teaching was also noted by most of the groups as part of the role; the following being an example from one student: *“the teaching of the clinical skills, especially when your buddy doesn't have time to”* (FG4 3rd year). *“[T]each us how to do things properly”* (FG3 2nd year) was another comment specific to teaching made by a student. This aspect of doing things correctly was also found in other comments, this one from the same focus group: *“if the clinical teacher wasn't here we could pick up on other nurses' bad habits”* (FG3 2nd year).

Assessment was another role of a clinical teacher that was identified by the students although the term was not used by any. It was indicated by comments such as *“if they find areas to help you improve on”* (FG2 3rd year) and *“give you areas where you need to improve”* (FG4 3rd year). This implies that the clinical teacher will give the student feedback however feedback was criticised by the students as will be seen later. *“[C]onstructive criticism”*(FG1 3rd year) and *“to challenge you”* (FG1 3rd year) were two other roles that one group saw as being part of the clinical teachers role although others may say that these are also attributes needed by the clinical teacher.

Attributes of an ideal clinical teacher

Attributes could be split into personal attributes and those more generally of the role of the clinical teacher. For example *“approachable”* (FG1 3rd year), *“understanding ... empathy”* (FG3 2nd year), *“confidence ... they need to be patient and understand[ing]”* (FG4 3rd year) and not *“timid”* (FG5 2nd year) are all more personal attributes while comments like *“someone who is not judgemental, or someone that takes time to do tutorials that sort of*

thing” (FG2 3rd year) and “*effectively giving ... feedback, able to give feedback*” (FG4 3rd year) relate more to the role of the clinical teacher. A clinical teacher being approachable also was mentioned in other sections of the focus group sessions as being an important attribute, for example this comment; “*being approachable, I recon, some teachers are really really [sic] good in their knowledge base but they’re scary to approach or they just jump down your throat*” (FG2 3rd year).

The comments about clinical teachers not being timid needs some further explaining. This was discussed by one group only although several of the students in the group made comments. Discussion started with the statement that the clinical teacher needs a

... strong persona too because sometimes teachers are very timid and scared to ... [continuing with the following after a few interjections] confront things, and I think that they should be very stern and especially when it comes to standing up for students in clinical situations [whilst also acknowledging they] ... should be able to deal with students and that’s the hard, one of the hard things to do with” (FG5 2nd year).

There was no indication that these students had had issues with any particular clinical teacher so it is hard to put these comments down to a bad experience; however it needs to be acknowledged that this could be the case.

The skills needed by a clinical teacher

Communication came out strongly in response to this question although it was not always expressed that way. The clinical teacher would be using good communication skills when they were encouraging or supporting students as in this comment; “*give that calming or encouragement constantly so that we don’t feel so scared or pull back*” (FG3 2nd year).

Also part of this is that the students want the clinical teacher to be approachable; “*they have to be approachable and sometimes all the teachers aren’t approachable in an [sic] way*” (FG2 3rd year). A comment from one group was that “*I think it’s important that the teacher is with us*” (FG5 2nd year); that is that the clinical teacher is available for them if needed.

One attribute coded as a sub-set of skill, however not mentioned under that question but in other sections of the interviews, was the clinical teacher being an advocate for the student/s. One group made minimal comments; *“also like if something goes wrong and like us as students get blamed like the clinical teacher can be there to support us [and another student added] be like an advocate”* (FG3 2nd year). The view from the other students was that either clinical teachers would not do this *“when they don’t speak up for you, ... upsetting because ... they don’t stick up for you”* (FG1 3rd year) or else they found it too hard to address issues and just had the students avoid them as this comment indicates; *“so my clinical teacher said just leave them, there is nothing I can do about it we’ll just go out and go somewhere else”* (FG1 3rd year). To be able to do the things that students suggest here the clinical teacher will need good communication skills to provide the support that students seem to want; however there may be other reasons why some of this support may not be able to be provided that the clinical teachers are not willing or able comment on to the students.

What sort of knowledge is it important for clinical teachers to have

Almost all of the groups commented on clinical aspects in reply to this question. In some cases it was *“a knowledge of the hospital and the wards that we are on”* (FG1 3rd year) that was seen as important while with others *“just like clinical skills in general”* (FG5 2nd year) and *“all the policies as well”* (FG3 2nd year). Some students did complain that some of the clinical teachers did not have the skills for the area they were working in; to some extent this can be offset by the following comment made by a student in reply to the skills question earlier in that focus group; *“someone who has a lot of experience in different areas, a wide variety of different place”* (FG2 3rd year) therefore it would appear that different students have different views about this. It may come to how well the clinical teacher can adapt and utilise the various skills and knowledge they have from different areas into another area.

One area that from other sources, for example comments by clinical teachers themselves and also the literature, was knowledge of the course and curriculum. Only one group mentioned this unprompted while it was asked as a clarifying question of the other groups. The one group that did mention this without any prompting said knowledge *“of the*

curriculum, about what's in it" (FG3 2nd year). Other comments to this question included these; *"to a point I think they need to know what you have learnt so then they know what you are capable of doing and where you've got a good knowledge base [followed on by another student] and they can help you out with what you're not competent in"* (FG4 3rd year). These comments would agree with there being a support function of the clinical teacher facilitating the students learning through knowing what they need to learn and develop while on the clinical placement.

Helpful and un-helpful actions on the part of the clinical teacher

There was only one helpful action which was discussed by one group. This was around clinical teachers who try and make use of experiences available for the whole group, rather than just one student on a particular ward being exposed to the experience. It was put this way by a student:

... because some teachers are very good at like say if you've got students on a medical wards and surgical wards and they want to experience different things some teachers are very good at saying well all right well we have an iron infusion today so people come down and have a look" (FG1 3rd year).

Even if they are not able to give all the students the experience of viewing it in person these clinical teachers *"then do an in-service thing in the class room and this is what we went through this is what we did whereas other teachers, it's too bad you missed it"* (FG1 3rd year). This again points to the clinical teacher facilitating the learning of students.

Some students and groups made comments about clinical teachers who were 'not present' which has been alluded to earlier. Here though examples were given by students as these comments from one group shows:

Student – when they're not easy to find or you ring them and they don't answer or don't get back to you,

Student – or when you only see them out of 18 shifts you only see them twice,

Student – exactly, or they just happen to appear when there's half an hour left of the shift and you've done everything,

Student – or they chain smoke outside, yea (FG1 3rd year).

While from another group; *“I had a teacher that was always downstairs, she was never found”* (FG3 2nd year).

Another issue is what one student described as *“judgemental”* (FG1 3rd year) and where students have issues with the clinical teacher being critical of them. The following is from another group that although they have used different terms the issues seem to be the similar:

Student – pretentiousness (some laughter)

Student – if they always think their right and they're, you know they get annoyed with you or if you don't know anything just a level of pride and you feel uncomfortable approaching them about something, so again it's the humility that's involved

Student – yea, sometimes some of them high expectations, a little bit too high like, you're a student, I had one in my first year who, ... just expect so much and it was my first ever placement, how can you expect me to know this within the first three days, and it was sort of quite can believe you don't know, she didn't say it in that respect but I can't believe you don't know that, how could I know it if I haven't done it, kind of thing” (FG5 2nd year).

Being reprimanded in front of a patient could also be seen to fit with this type of approach by a clinical teacher; the following are comments on this happening:

Student – ... and they are telling you off in front of the patient

Student – unprofessional, ...

Student – degrading and they, you feel like you can't get back to that patient so you've been put down by the clinical teacher so your

practice is poor so the patient thinks that, been told off in front of the patient by the clinical teacher but that's the case (FG4 3rd year).

All of these are issues that can cause problems with the relationship between the clinical teacher and the student which are not positive for the student and so could lead to a decrease in their ability to learn on the placement.

The assessment process

Students' comments on assessment

There was confusion on what work was expected from the students. Although the unit guides make it relatively clear as to what is expected for each clinical unit this does not seem to be applied universally by the clinical teachers; *“yea it's been ... [variable] across the three years, whether we have to [do] a care plan every, every placement others we have to do a reflective journals every placement”* (FG2 3rd year). Some of this may be due to the clinical teacher not keeping up to date and applying requirements from previous year's units to the current one. In some cases it is seen as extra work by the students while they also feel a sense of confusion about it as they never know what is expected of them until they arrive at the placement, and even then it can change:

... you find some teachers ask you to do extra work on top of what you are already doing and then others say well don't worry about any of it we'll just chat about it and things ... [you] like to turn up to a placement knowing what's expected of you whereas some of them you turn up and don't know you have to fluff through, sometimes they will say in the first day... you have to do this but don't worry about it and then two and a half weeks later they are chasing you for it (FG1 3rd year)

There was also some criticism of clinical teachers who take an easy route to completing the documents. One student told of this example:

... there's been placements where they've made us fill the formative one out, which is good and bad in a way because when they come to the summative they'll just go off the formative, and they just sort of

look for examples that you know what you're talking about but they don't really offer any criticism in return as they're just going off what you've said" (FG1 3rd year).

Following on from this another student told this story; *"there's one where ... the teacher that I never actually saw only twice asked me, told me what to write there and took a photocopy that looked good for that particular hospital"* (FG1 3rd year). This raises the question of how useful is this feedback to both the student, the university and where the documents are used in Graduate Year interviews, the hospital, where this sort of thing is happening? This links to earlier comments about who is reading these documents and what do they want out of them. If it is for others to read then the comments should be directed in that way, which in the above may relate to the comments about making the hospital look good, but if it is about giving feedback to the students to help them develop then this sort of action may not be useful at all.

Competencies and the Bondy scale

This area was probably the one with the strongest views expressed by students in particular around the clinical teachers' use of the Bondy scale. What seems to have caused this is the inconsistency in the way the Bondy scale is used by the clinical teachers, summed up by this comment:

... some will say oh well you can't possibly get four no matter how competent you are because if you were at four you would already be a registered nurse whereas others say no that's you can get a four because it depends on that placement, its rated on that placement ... one placement you will just pass because the teacher won't do fours the next one you'll fly through it so you have no indication what your competency is" (FG1 3rd year).

This seems to be universal as another student commented; *"Yea, so that was one, one big thing that everyone's queried every placement so far"* (FG2 3rd year) followed later by this comment *"you know some people who have got close to forty on placements whereas*

others have got, you know close to thirty ... it's just because their educators assessed differently" (FG2 3rd year).

For the second year students that formed two of the focus groups their clinical placement is graded using the Bondy scale. This produced some issues for them. As there is a numerical score attached to the Bondy levels (as commented on above) this score is used to produce a grade. Therefore if a student only gains two's for all competencies they will only gain a pass mark yet students will say *"I want an HD, I got HD's last year and I want HD's this year"* (FG5 2nd year).

As with any tool like the Bondy scale there needs to be a consistency and consensus to what is actually graded. If the clinical teachers/educators are working in isolation this may be difficult to acquire whereas the use of workshops where they meet and discuss the grading there is more likely to be consensus on the levels applied.

Feedback from the clinical teachers

Students' experiences were quite variable with feedback from the clinical teachers. Some students' experiences were very poor; *"I didn't really have much feedback"* (FG2 3rd year), whereas others did receive some; *"some of the teachers give you feedback when they are giving me the assessment back but they didn't write it in the assessment because we have to take it in [for Graduate Year interviews]"* (FG2 3rd year) and from this student who seemed to be quite pro-active in seeking feedback:

[I] find it good I generally like to ask my teachers half way through and say what is it you think I can improve on but they generally pretty good they'll say this is what I think you are lacking in or you can do better in ... and they'll explain it to you" (FG1 3rd year).

The general experience seemed to be that at the time of getting their formative or summative assessment they got very little; *"mine just said good job, and that was it, I didn't get anything constructive"* (FG2 3rd year).

One group made comments about who gives them feedback while they are on clinical placement. In their view it should be the buddy nurse, the nurse they are working with

rather than the buddy nurse giving information to the clinical teacher and then the clinical teacher giving it to the student. There may be an element of misunderstanding that it has to be the clinical teacher who does this as one student commented; *“I think it’s our clinical teachers who have to do, I think our buddies will go ahead and tell the clinical teacher what is happening and our clinical teacher needs to speak with the student”* (FG3 2nd year). The main student who commented on this felt it was a communication problem and that

... people are too busy, or you know I’m sure the staff at the hospital as well will have 15 minutes, just even 10 or even stop just to say this is where you are going wrong and I wish you will ... actually focus on this, that would be very, very helpful for a student” (FG3 2nd year).

This is at odds with comments made by the clinical teachers in their interviews where they say they give the students plenty of feedback, although much of it is given verbally as acknowledged by some of these students. The issue may be, as discussed later, that the students do not realise that even verbal comments are a form of feedback, although more informal than written feedback as found on the assessment documents.

Section summary

The students saw that clinical teachers have three roles, support, teaching and assessment. Good communication skills were seen as important in relation to these areas with the clinical teacher needing to be both approachable and present as examples were given where the students stated that some were often absent. There were also issues identified with the attitudes of some clinical teachers; *“judgemental”* (FG1 3rd year), *“pretentiousness”* (FG5 2nd year) and *“telling you off in front of the patient”* (FG4 3rd year) indicating the opposite of being approachable.

As part of the assessment comments there is the implication that clinical teachers give feedback on the student’s progress however in a later section many students commented that there was a lack of feedback from the clinical teachers and if it was given it was usually verbal rather than written. There was also a comment that some of the students felt that the feedback should come from the buddy nurses rather than the clinical teachers who

usually obtain information about student's progress from the buddy nurses. The Bondy scale was also problematic for students, in particular the variation between clinical teachers in its application. A particular problem where it is used to give a grade as with the second year student groups, as students desire to obtain a high grade, not just a pass, however some clinical teachers would not use the whole range of the scale.

Chapter summary

This chapter has presented the data from the five separate data sources, participant observation reports from the clinical teacher workshops, documentary analysis of the clinical assessment forms from the same period as the workshops, two sets of clinical teacher interviews from the start and end of the data collection and a set of student focus groups recorded at the end of the data collection.

Within these data sets there were some common themes identified. The roles of the clinical teacher were one. Assessment and teaching is inherent in the role however there was also a facilitation role, identified and named by both clinical teachers and student. Some of what was described could also be seen as teaching but other parts, such as working with venue staff to gain good experiences for students is a different type of facilitation. Good communication skills were seen as important for good clinical teachers. These are useful in both the teaching and facilitation role. Issues were identified in the student focus groups of clinical teachers being absent or displaying attitudes that hindered the student approaching them. Feedback to the students, or rather the lack of it, was identified in all the data sets to various extents. In the CPAT data questions were raised about the usefulness of the written comments; in some ways supported in the clinical teacher interviews where they commented that they did not write about areas of poor performance as the students use these forms for graduate year interviews, a comment supported by the students. The clinical teachers did however say that they gave good verbal feedback to the students, both over the course of the placement and when giving them their CPATs. This was at odds with the student focus group views where they felt that they did not get good feedback, either written or verbal. An area where there was consistency in comments between the clinical teachers and students was regarding the use of the Bondy scale for assessment. Both groups felt that there was not consistency in its application, different clinical teachers having

different views about how it should be applied, a concern for the second year student focus groups as the score from the Bondy scale was used to give them a grade for the unit.

The next chapter will expand on these comments by comparing the data across the different sources to provide more depth to the analysis.

Chapter 5:

The complex roles of a clinical teacher and a model of developing expertise

Introduction

This chapter will present the complex roles of a clinical teacher and a model of developing expertise through the lens of the findings from the research. Its aim is to bring the data which was presented in the previous chapter (the two sets of clinical teacher interviews, the student focus groups, the clinical teacher workshops reports and the review of the clinical assessment document) together to illustrate the complexities of the role and to present a model of how clinical teachers progress from being novices to experts.

It is pertinent here to revisit the aim of the study and the research questions. The study aimed to critically examine the factors that have an impact on how the clinical teacher is able to perform their role and to propose how an understanding of these factors can aid in the professional development of a highly accomplished clinical teacher in nursing education.

The three key questions for the research were:

1. What are the complexities of the practice of the clinical teacher?
2. What are the skills, knowledge and attributes of an accomplished clinical teacher?
3. How can this knowledge of skills, knowledge and practice be used in the professional development of clinical teachers?

The structure of the chapter will be framed by these three questions. First it will identify the complexities of the practice of a clinical teacher through describing what it is that they do. Secondly, the discussion will identify the skills inherent in an accomplished clinical teacher. Finally a model of how this understanding can be used to aid in the development of clinical teachers is presented. An understanding of the work of clinical teachers will be arrived at using Pring's (2004) "framework of concepts and beliefs" (p. 77).

The previous chapter (Chapter 4) reported data gathered from different sources producing five data sets. Each set does not give a full picture to answer the research questions. It is necessary to synthesise the data sets in order to fully answer the research questions. The current chapter will present this synthesis.

The core nursing skills a clinical teacher has already developed are a necessary basis for work as a clinical teacher. Clinical teachers must be registered nurses who demonstrate the core skills of a nurse. The registered nurse usually has some years of clinical experience before becoming a clinical teacher. In the National Competency Standards for the Registered Nurse the following four domains are recognised; “Professional Practice ... Critical Thinking and Analysis ... Provision and Coordination of Care ... [and] Collaborative and Therapeutic Practice” (Australian Nursing and Midwifery Council, 2005, p. 2). These are the core skills required by all nurses to enable them to fulfil a nursing role. Nurses also make use of professional knowledge; how to care for a person with a particular disease, for example, what signs to look out for post operatively to identify problems early, what to do if a person’s blood glucose level is low and how to perform Cardio-Pulmonary Resuscitation. These are skills learnt during their initial nursing education and further develop over time. They are skills that are adaptable and are used in most nursing situations and can be linked to the three learning domains.

All three of the learning domains are required to be used by nurses and can be seen within nursing practice, including that of clinical teachers. The psychomotor domain can be seen in the practical aspects of nursing care, the giving of medications and carrying out dressings, for example. The cognitive domain is seen when the nurse has to make sense of a patient’s change in observations and deciding if this is significant or not and whether to report these to a doctor or in the planning of care for a patient. The affective domain can be seen in their communication skills and the way they interact with peers, patients and relatives. These will be explored in more depth when discussing the complexities of the role of a clinical teacher.

If the nurse moves into clinical teaching these skills will still be used, but in different ways; however the core skills remain, it is rather the way in which these skills are utilised that

changes. McLeod et al., (2009) drawing on Reynolds, say that clinical teachers develop skills “which facilitates the translation of content expertise [core skills] into a form that can be readily understood and learned by students” (p. e117). The nurse will use communication to do this, as well as to educate and give feedback on student assessment or communicate issues to academic staff. Professional knowledge will be drawn upon to know what to teach students, to help guide the student in how to care for a particular patient, and to know if actions are carried out correctly as part of the assessment process. Participants, both the clinical teachers and student nurses in the current study, agreed that strong clinical experience and background was important for the role.

The nurse contemplating becoming a clinical teacher may have also developed some beginning skills in the area of teaching, in particular if they have been a preceptor. However, it is possible that these will probably focus on psychomotor skills. Psychomotor skills may include educating a patient about how to give themselves an injection and assessing if it is being done correctly, or presenting knowledge about an illness and how that may affect the person. This is different to the more complex process of working out what is suitable care for that person which requires different skills in the nurse, and an understanding of this needs to be passed on to students.

Discussions in the literature identified that certain personal attributes in a clinical teacher are favoured by students. In the current study students in the focus groups identified being approachable, having patience and empathy as being helpful attributes in a clinical teacher. In replications of Knox and Morgan’s (1985) earlier study both Nehring (1990) in the USA and Kotzabassaki et al. (1997) in Greece found these attributes tended to come high on the list for the ‘best’ clinical teachers. Nursing is not the only health discipline that finds these attributes to be helpful for students as reported in Bennett’s (2003) work from physiotherapy where approachability was the highest ranked attribute.

Other attributes of a good clinical teacher have been identified in the literature. Among these, the ability to give feedback is presented as being important (Bennett, 2003; Kelly, 2007; Kilminster & Jolly, 2000). Feedback was an issue identified in the current study and

has been further commented on in relation to both the education and assessment role of the clinical teacher in later sections of this chapter.

As the nurse moves from the role of clinical nurse, where they may well have been working at an experienced level, to that of clinical teacher, where they may well be a novice or advanced beginner, the core skills form the basis of their development with the addition of other skills until transition to the role of clinical teacher is achieved. The current study has identified that the role of the clinical teacher is a complex one made up of three distinct skill areas needed. The next section will expand on the complexities of the role and present these three skill areas in detail.

The complexities of practice for the clinical teacher

The role of a clinical teacher is a complex one. To help understand this in relation to the development of clinical teachers, three themes emerged from the data, a facilitative role, an educative role and finally an assessment role. The following table (Table 19) lists the various elements identified within each role. The three themes along with the descriptors used in the table are taken from the data sources presented in chapter 4 and are either the codes used in the analysis or another term that represents the idea more appropriately. (The codes taken from the interviews and focus group interviews are presented in a table structure in Appendix 7.)

Table 19

Elements identified within each role

| Facilitation role | Educative role | Assessment role |
|---|--|--|
| Consolidate learning in the clinical setting | Offer more knowledge | Making an assessment |
| Appropriate allocation of patients to students | Demonstrate – Teaching of the clinical skills | Techniques Feedback from the venue staff |
| Smoothing the way – liaising with placement staff if needed | Articulate – Help you put theory into practice | Variation in assessment – Objective v subjective aspects |
| Supporting the student | Challenge you | Assessment forms and Failure to fail students |
| Personal support | Feedback – which is discussed including the following | Graded assessment |
| A nurturing role | Give students ongoing direction – give you areas where you need to improve | Work required of students |
| | Verbal feedback | Assessing the affective domain |
| | Make students recognise they're getting feedback | |
| | Comments without support | |
| | Working with a student that requires more of the clinical teachers time | |

These are key aspects of the role that are critical to the work of the clinical teacher. They have to some extent been identified before yet do not appear to have been named as such. For example Forbes (2010) has identified that “students require a supportive learning environment ... a teacher who negotiates learning experiences [part of a facilitative role] ... provides guidance ... and diagnoses learning problems [part of an educative role]” (pp. 785-786). The three themes build on and develop from the core nursing skills of the nurse who moves into clinical teaching. These themes relate to each other and some actions could be identified as belonging to more than one of these areas depending on what the intent of the action was. The following example was gathered from a student focus group:

... if you've got students on a medical wards and surgical wards and they want to experience different things some teachers are very good at saying well all right well we have an iron infusion today so people come down and have a look (FG1)

This practice could be seen as either facilitating learning by giving the students an opportunity to see something different or as teaching in the sense that ‘this is how it is done’. The idea of overlapping roles will be developed further. Once these roles are understood it will then be possible to plan the development of clinical teachers so that they can better fulfil their role. The next sections will discuss the facilitative role, the educative role and the assessment role in more detail.

The facilitative role of the clinical teacher

The clinical teacher uses facilitation in many ways in providing a supportive environment for students both to enhance the learning opportunities for the students as well as to support them professionally and personally if needed. This does not mean that the clinical teacher will use all of these actions every day, or even in every placement to which they are allocated. They are likely, however, to use these skills at some point in their time as a clinical teacher. As part of the facilitation process the clinical teacher may also have to manage people to facilitate the outcome that is desired, for example, the allocation of a particular patient to help meet a student’s learning needs. It is the outcome that is facilitated, not the process. The following elements of facilitation were identified in the data:

- Consolidate learning in the clinical setting
- Appropriate allocation of patients to students
- Smoothing the way – liaising with placement staff if needed
- Supporting the student
 - Personal support
 - A nurturing role

Consolidate learning in the clinical setting

There is support in the literature for the consolidation of learning in the clinical setting in the teaching role of the clinical teacher. Forbes (2010), (citing “Landmark et al 2003”) states; “In particular, teachers help students to make the links between theory and practice” (p. 785). One clinical teacher participant talked of facilitation where “*we facilitate their learning in order for them to apply what they've been taught already*” (CT3 1st interview). Further support comes from another participant when they said part of the role is to “*give it some relevance*” (CT4 First interview), ‘it’ being what the students had been taught at university. There are two ways to achieve an outcome; one is through teaching (discussed later), while the other is by giving the student the opportunity to put the learning from university into practice.

By facilitating opportunities for the student to put theory into practice the student will deepen their knowledge and understanding of the information taught within the theory units associated with the clinical practicum. For example if the student has been learning about the care of Intra-Venous (IV) fluids, when they work with these they will further develop and consolidate the skills in the area. If they do not have an opportunity to practice these skills they may lose them, or at least require remedial teaching in a later placement. Automaticity can be developed through practice as “In complex environments automaticity allows cognitive resources to be reinvested in other and higher level cognitive activity” (Berliner, 2001, p. 474). An example is the experienced nurse who is able to talk to a patient while completing a dressing while a student may not, the student needs to focus on the task, the technique of completing the dressing correctly. Thus, through practice the

student can develop their skills and allow them to concentrate less on the task and more on the cognitive elements around the task.

Being able to apply their knowledge is important. Clinical practice allows students to contextualize their theoretical knowledge and apply it in practice. Carlson, Pilhammar, & Wann-Hansson (2010) state that preceptors “facilitate opportunities for students to internalize knowledge, skills and ethical views” (p. 766) supporting a facilitation role for clinical educators. A further way that clinical teachers can facilitate learning was identified in one of the student focus groups. Students commented on a clinical teacher who would call them to another ward if there was something significant to see that generally the students would not be exposed to; *“one who ... picks you out and says come watch this ... I think you need to see this”* (FG 1). However, other ways of support were described by students: *“obviously everyone can not have a look so they then do an in-service thing in the class room and this is what we went through, this is what we did”* (FG 1).

Appropriate allocation of patients

Thinking about students’ learning needs is one reason that clinical teachers become involved in the allocation of patients to students. One of the novice clinical teacher participants said they would make the most of any allocation the student was given. The clinical teacher would endeavour to maximise the student’s experience within the allocation for the student *“often you’ll just make the most of an allocation”* (CT4 Second interview) although the comment was not expanded upon. My experience is that most clinical teachers leave the allocation of students to patients up to the ward staff and do not become involved unless there is some clearly identified reason to become involved, for example *“if they’re given four of the heaviest patients ... that’s definitely not fair”* (CT6 Second interview).

It needs to be noted that not one of the participants mentioned the students’ learning needs or facilitating an allocation to help meet their needs in the interviews, even though one of the requirements of the position as stated in the Position Description used at the School of Nursing used in this study is:

Selection of patient assignments [allocation] and student responsibilities in collaboration with clinical agency staff and timely communication of this information to students in order to allow them adequate preparation time where this is a requirement of the subject. (Victoria University, 2010, p. 2)

In relation to the allocation of patients to students on placement Croxon & Maginnis (2009) report on a change of student support in their clinical practicum. The reason for this was that “many students reported being delegated repetitive basic care such as showering, bed making and observations” and “Practical experience was not correlating to the theoretical preparation they had received prior to the placement” (Croxon & Maginnis, 2009, p. 237). This is an important issue as, due to limited clinical placement time in nursing courses, “it is essential that the time available is focused on the students’ need rather than service needs” (Croxon & Maginnis, 2009, p. 240).

One of the experienced clinical teacher participants did indicate that they would become involved if they felt the student was given an allocation that gave them an unfair workload. This would occur, for example, when the student is allocated a patient with whom the ward staff preferred not to work: “*students being unduly given someone because staff don’t want that person*” (CT6 Second interview). There is a link to the next form of facilitation that of smoothing the way for students’, in some cases dealing with these sorts of problems can make the clinical experience for the student smoother.

Smoothing the way

The clinical teachers saw part of their role as smoothing out any difficulties there may be between students and the clinical staff. The previous comment on allocation of an unpopular patient is one example of this. Both clinical teacher and student participants commented on the clinical teacher acting as a bridge between the student and clinical staff, to prevent disruption of the students’ learning. As one student put it, to “*be like an advocate*” for the students (FG 3), if there were problems between the staff and students the clinical teacher could step in. One clinical teacher commented “*you are there to work out something for them [the student]*” (CT4 First interview). By working in such a fashion the

clinical teachers are making the student experience run more smoothly and therefore the student is likely to be more comfortable with the placement and be more receptive to learning.

Some of the student participants did not feel that this was happening. One student commented that “*they [the clinical teacher] don’t want to speak up [for you]*” (FG 1). The students found this disheartening particularly when it occurred early in the course or placement.

Supporting the student

Two other forms of support were identified in the interviews and focus groups. Although they are similar in many ways it is useful to discuss them separately as they each have a different focus. These are personal support and a nurturing role which are discussed in this order.

Personal support

Two clinical teacher participants commented that students come to them if they have problems needing personal support. In one case the actual problem was not specified. The second clinical teacher described dealing with personal problems and giving advice to help the student and resolve the problem. Providing support for personal problems has been identified in the literature as something provided by clinical teachers (McKenna & Wellard, 2009). Baxter and Rideout (2006) identified that students accessed the clinical teacher for “emotional support” (p. 126). However the authors did not specify what they meant by the term.

Students are faced with many challenges during their practicum, some of which may be difficult to cope with. For many students it will be the first time they have to undress and bath a person or seeing somebody who is dying or death itself. Younger students may have problems in coping with these aspects of nursing, in particular death (Terry & Carroll, 2008). In these instances the clinical teacher can provide emotional support to the student. In some ways the clinical teacher is better placed to do this as, unlike ward staff and the

mentors mentioned by Terry and Carroll (2008), they can spend time with the student/s as they are not part of the ward staff with a patient load.

A nurturing role

One of the clinical teachers talked about nurturing and it was taken up by another when discussing ways of helping the student develop into the role of a Registered nurse; “*students need to feel like someone is taking them under their wing ... [the need to feel that] somebody cares about their development*” (CT4 Second interview). Nurturing has been linked to mothering. McKenna and Wellard (2009) state their participants “described ‘mothering’ students by being sensitive to their emotional and social wellbeing during clinical practicum and assisted them to deal with issues as they arose” (p. 278). However when commented upon in the interviews, mothering was not seen as a positive role. A participant recognised that nurturing can become problematic if a mothering role developed:

You need to facilitate that role of breaking the apron strings [with the students] ... no I’m not here to do for you, ... you got to get out of that mother role, you’ve got to do it because if you don’t do that, they will hang on you like there is no tomorrow, and they will manipulate you (CT2 Second interview).

An experienced clinical teacher already recognised the issue in a comment regarding boundaries “*it’s a professional not a mothering role*” (CT6 Second interview).

McKenna and Wellard (2009) do not mention any negative aspects of mothering although the two comments made above would suggest that at least some clinical teachers do see it as problematic. McKenna and Wellard (2009) say that their findings were “initially surprising and disappointing” (p. 283) and go on to theorise that “The dominant discourses in contemporary nurse education position students as adult learners who are self-reliant” (p. 283) suggesting that mothering is not needed.

Modelling the affective domain

Shephard (2008), in talking about the affective domain states:

The affective domain is about our values, attitudes and behaviours. It includes, in a hierarchy, an ability to listen, to respond in interactions with others, to demonstrate attitudes or values appropriate to particular situations, to demonstrate balance and consideration (p. 88).

In working to achieve facilitation the clinical teachers are using aspects of the affective domain, listening to their students and others and they are responding to these through their interactions. They are demonstrating attitudes or values when they are supporting the students learning needs or attempting to adjust patient allocations if this is in-appropriate. Balance and consideration can be seen in the judgements and advice that they give to students.

It could also be argued that there is an element of role modelling of the affective domain by the actions of clinical teachers. The way a clinical teacher deals with issues and the way they interact with others, especially at the professional level or in the way they deal with students that have personal issues gives the students a role model as to how they could handle such situations when confronted by them.

Knotworking

Engeström's concept of knotworking is helpful in understanding the situation the clinical teachers have to work in to bring about facilitation. In knotworking "The notion of knot refers to a rapidly pulsating, distributed and partially improvised orchestration of collaborative performances between otherwise loosely connected actors and activity systems" (Engeström, et al., 1999, p. 346). This would fit with the situations that clinical teachers work in, they work in a loose arrangement with the clinical staff in the clinical areas the students are placed in along with patients whose conditions can change frequently. To add to the complexity "Knotworking situations are fragile because they rely on fast accomplishment of intersubjective understanding, distributed control and coordinated action between actors who otherwise have relatively little to do with each other" (Engeström, et al., 1999, p. 352). Often the clinical teacher will not know any of the staff who is working in the clinical area, particularly if they do not work for that institution, nor

will they have met the students until the commencement of the placement. The clinical teacher will need to get to know both the clinical staff quickly so that they have some idea of who is supportive, who is not, who can get things changed or done as well as gain a quick overview of the students' abilities, knowledge and skills to be able to guide and support them, particularly if the placement is a short one of two weeks.

The clinical staff will often have their own agenda and way of working with students that may be different from the clinical teachers. It is therefore important that clinical teachers have good communication skills to help deal with these situations as "Different interests, meanings and practices [have] to be negotiated continually in the ... knot" (Fenwick, 2007, p. 150). Fenwick (2007) adds "Those who thrive in the knots appear to be continually self-reflexive to their own implication and strategies in the unfolding languages, the connections and disconnections, at both the micro and macro levels" (p. 151).

Not feeling comfortable or having difficulties with the facilitative aspect of the work may be one of the reasons why some clinical teachers do not continue working in the role. In particular those who have difficulty coping with the fluid situations described by Engeström's (1999) knotworking. Fenwick (2007) identified that "Not all individuals were able to function effectively with this discursive informality and loose interconnections" giving the example of "One administrator [who] left, citing frustration in the lack of order" (p. 145).

Summary

This section has discussed the facilitation aspect of the clinical teachers' role. The clinical teacher acts as a facilitator to enhance the learning opportunities for the students as well as to support them both professionally and personally if needed. Much of the work that the clinical teacher does in this area comes from the affective domain and as such could be considered to be modelling this for students. Engeström's (1999) knotworking concept was introduced to provide a framework for the situation the clinical teachers work within. A focus of the discussion was on the students' learning; it is appropriate now to consider the educative role of the clinical teacher.

The educative role of the clinical teacher

A second role, implicit in the name clinical teacher, is that of educator of the student in the clinical setting. Some of the actions described here could be seen to be part of the facilitation of learning as described above as they aid the student to put ‘theory into practice’. However the educative role is related more specifically to teaching. The educative role of the clinical teacher featured in the clinical teacher interviews and the student focus groups as well as being identified in the clinical teacher workshops. The following were identified as sub-themes from the interview and focus group data with the first four themes being taken from participant comments. The final two themes were issues that were identified both in the data and from the literature. The discussion will continue under these headings:

- Offer more knowledge
- Demonstrate – Teach clinical skills
- Articulate – Help you put theory into practice
- Challenge you
- Feedback including:
 - Give students ongoing direction – Give you areas where you need to improve
 - Verbal feedback
 - Make students recognise they’re getting feedback
 - Comments without support
- Working with a student who requires more of the clinical teacher’s time

Offer more knowledge

One of the ways that the clinical teacher can perform an educative role is seen in a comment from one of the students in a focus group when they said “*they offer more knowledge like stuff that they know that you might not know*” (FG 4). Offering more may not be as easy as it seems as what is more knowledge for one student may not be for another as illustrated in a comment from one of the clinical teachers talking about students learning needs and the way they may deal with these:

... you need to highlight peoples' learning needs and people are at very different levels, and if some people are finding it difficult with the fundamentals then you just focus on the fundamentals before you move on to anything advanced (CT4 First interview).

Experienced clinical teachers recognise that students are at different levels and there is a need to adjust teaching to accommodate differences. Dealing with students with different learning needs is not unique to nursing clinical education and has been recognised in the literature for a long time, for example in teaching (Reynolds, 1992). This is sometimes referred to as “a student centred approach, in which the emphasis is on students and what they learn, [which] requires a fundamental change in the role of the educator from that of a didactic teacher to that of a facilitator of learning” (Spencer & Jordan, 1999, p. 1280). The participant above was referring to core skills, identified as ‘fundamentals’ which need to be in place before the more complex skills of nursing can be addressed.

There are many ways that clinical teachers can offer more knowledge to students. In the facilitation section it was mentioned that students could be taken to another area to view something that they would not normally be able to see. Where it is not possible the student said that “*obviously everyone cannot have a look so they then do an in-service ... in the class room and this is what we went through this is what we did*” (FG 1).

The next two themes demonstrate and articulate techniques that can be used to help the student expand their knowledge of clinical work.

Demonstrate – Teach clinical skills

In relation to meeting students' learning needs one clinical teacher commented that their role was to identify “*any learning shortfalls you might pick up on ... you actually demonstrate to them and teach them*” (CT 1 Second interview. Emphasis added). Nursing is composed of many skills including psychomotor skills. The common way to teach psychomotor skills is to demonstrate these to the students and have them perform return demonstrations to show they have understood. Although this often occurs at the university in nursing laboratories it is necessary for clinical teachers to have to re-demonstrate these in

the clinical setting for a variety of reasons. These may include the student missing the session at university, needing to be refreshed on the skill or the demonstration of new or different equipment. Clinical teachers, who are usually expert clinicians, can also help students develop improved skills through demonstrating or coaching improved or alternative techniques to students. In this they are using their experiences as an expert practitioner to help develop the skills of a novice practitioner as they are more likely to have a wider repertoire of skills and techniques than a novice nurse.

Putting theory into practice

In one of the student focus groups, one participant identified the role of the clinical teacher as to “*help you put your theory into practice*” (FG 4). One of the clinical teachers also noted the bringing of theory and practice together in the role: “*you need to be able to ... articulate to the students like a disease process or clarify it or break it down to a point where it’s understandable for them*” (CT 2 Second interview). This aspect of the role relates to the cognitive learning domain as it is about the students’ knowledge and use of that knowledge, the ‘putting theory into practice’.

There was a belief by students, put clearly by one group and implied by others, that the clinical teacher should be there “*to answer questions*” (FG 5). This is not an unreasonable point as the clinical teacher is an educator and a role of an educator is to provide information. However one of the experienced clinical teachers implied some problems with this statement:

... they’re trying to score a lot of information from the clinical teacher for some things they should [know] themselves so ... sometimes I believe they feel you need to be a walking dictionary and have the answer for them right then and there (CT6 Second interview).

There is a risk that if the clinical teacher provides all the information for students as they require it, it may tend to produce surface learning in these students. Superficial learning is described by Wilson Smith and Colby (2007) as an “*approach [that] involves minimum engagement with the task, typically a focus on memorization or applying procedures that do*

not involve reflection, and usually an intention to gain a passing grade” (p. 206) thus the student can be quite happy to let the clinical teacher provide the information they require rather than try to understand it themselves.

However if the clinical teacher takes a deep approach to helping the student understand the theory in relation to practice they are taking an “approach to learning [that] involves an intention to understand and impose meaning. Here, the student focuses on relationships between various aspects of the content, formulates hypotheses or beliefs about the structure of the problem or concept” (Wilson Smith & Colby, 2007, p. 206), hence they will have a deeper understanding of their practice. One way that this can occur is through challenge.

Being challenged

Students in the focus groups identified ‘being challenged’ as part of the role of the clinical teacher, “*it’s also ... about challenge, the clinical teachers can challenge you ...*” (FG 4). One of the clinical teachers also recognised that they needed to challenge poorer students, “*they need to be challenged*” (CT 2 Second interview). It is another area where there could be overlap between the three roles of the clinical teacher as it could also be used as a means of assessment. It is used here as a means to understand what the student knows and to stretch their knowledge by identifying to them gaps in their knowledge. The finding is consistent with students from other disciplines. Cole and Wessel (2008), investigating physiotherapy students, identified the same attribute in their findings, stating that students “reported positive learning experiences when their CIs: [clinical instructors] ... challenged the student to frame questions, find answers, and “think further” ” (p. 166). Another way to do this is through feedback.

Feedback

“Feedback ... is designed to improve future performance” (Gigante, Dell, & Sharkey, 2011, p. 205) thus is part of educating students. Another view is that feedback “is seen as information given to specify the level of competence that has been attained in the performance of a specific task” (Fitzgerald, et al., 2010, p. 161) although the comment

could be more related to summative feedback during assessment rather than as an educational or formative process.

Informal feedback can be given at any time although recognition that this is being given can be problematic as will be discussed later. “Formal, written feedback” (Sherwin & Muir, 2011, p. 236) is what many recognise as feedback and is found in the assessment documents used at the mid-point and end of clinical placements. Waiting for these points can be problematic as “If feedback is deferred too long the learner may forget the context or may not have the opportunity to practice and demonstrate improvement” (Gigante, et al., 2011, p. 205).

Feedback is an important aspect of student nurse’s experience in clinical placements. For example in a 1996 conference paper on modelling behaviours , it was stated that “... performing procedures, with verbal instruction/feedback [w]as most helpful or affirming ...” which would indicate that receiving verbal feedback was a positive experience for students (Valentine, 1997, p. 245).

Providing direction

If the aim is to improve performance then clinical teachers are required to give students feedback regarding their learning needs and provide direction so that students can improve their practice. In the first interviews there was some acknowledgement of it happening:

I think, with the formative [assessment] ... if you point out their deficiencies at least they've got something to work towards, so at the end of it you would hope, that your assessment at the end of it would be a successful assessment (CT 1 First interview).

As already pointed out, the effect of feedback can be reduced by waiting for formal assessment time. Sherwin (2011) provides support for not delaying feedback in the comment “Immediate feedback ... is seen as being the most valuable” (p. 234).

The type of feedback students appreciate can be found in responses such as: “*give you areas where you need to improve*” (FG4) and “*constructive criticism*” (FG1). The first of these is the aim of formative assessment, the purpose of which is to improve future

performance. The second is a comment about the way feedback can be given. “We all know the importance of constructive feedback” (Tanner, 2005, p. 151) and “... all feedback needs to be given in a constructive, supportive and sensitive manner” (Sherwin & Muir, 2011, p. 235). Constructive feedback is described as being “... an interactive process of critique that provides learners with insight for the purpose of correcting errors and enhancing learning. It should be followed by advice for improvement” (Altmiller, 2012, p. 366).

One way that clinical teachers can give constructive feedback that directs future learning is in their comments written on the Clinical Performance Assessment Form (CPAF). Sections of the first CPAF analysis were coded as ‘Learning direction’ as it was quite apparent that the comments being made were ones that would direct the students’ future learning. As further rounds of CPAFs were collected the number of comments coded as such fell away significantly. It should be noted that the initial set of CPAFs contained both a formative and summative section whereas with the later ones only the summative section was available for the research. Hence these learning direction comments may have been made in the formative copy of the CPAFs. As the collected CPAFs were from second year students, it could be expected that the students still have learning to do to complete their course; therefore some further direction of their learning needs could be included in the summative document to guide them in their course completion.

Forms of feedback

Feedback was given more by verbal means than documented. As one clinical teacher succinctly put it:

When you have your discussion with them, if they have a three or a two [the level of the Bondy score given] ... you go through that with them, “you know you needed a lot of help in this area”, “maybe you need to expand in that area”, you have that formal discussion with them when you do their assessment (CT2 Second interview).

It is possible that clinical teachers may be reluctant to write comments about areas that need improvement, as students are asked to produce these documents for their Graduate year applications; “you have to be very careful in what you write on their ... [CPAF] because

that was actually produced for their employment, or could be produced for their employment” (CT 2 First interview). The students also noted concerns related to the forms being used to gain Graduate year positions; *“some of the teachers give you feedback when they are giving me the assessment back but they didn’t write it in the assessment because we have to take it in [for our interviews]”* (FG 2). From these comments it can be assumed that both students and clinical teachers have an understanding of why some comments are not written on the forms as negative comments may be detrimental to the student in their applications for Graduate Year positions. This is not without its problems though, as often the comments made are not helpful to readers needing to quickly assess the students’ performance. A participant in the second interview, who now works as a hospital educator, made the following statement in relation to a question about comments made on the CPAF:

I think that honestly with those appraisals because I read them now, minimal information on the appraisals ... in terms of how does the student actually perform, you’ve told me a little bit about them but you haven’t mentioned anything about communication, anything about teamwork, anything about all of those professional issues that an employer may be interested in, and as students that’s the only resource they’ve got to bring to interview (CT4 Second interview).

The lack of clear feedback on the assessment documents could be detrimental to the student as if they have in writing only positive or neutral comments they may feel that they are progressing satisfactorily. They may forget, or not value, verbal comments as much as the written ones, an issue identified in the literature. A point made by Gigante et al. (2011) who comment; “Learners may also interpret an absence of feedback as implicit approval of their performance” (p. 206).

Research conducted on mentor documents in the United Kingdom found that “There appeared to be reluctance on the part of the mentors to highlight difficulties/issues with students directly who were not performing as expected” (Fitzgerald, et al., 2010, p. 161). Fitzgerald, et al. used confidential feedback forms that the students did not see for mentors to give additional information to the university. Based on the comments on these forms the authors commented that “This confidential feedback appeared to be more honest. Our

findings appear to illustrate a much deeper issue of inconsistency and a lack of ability to give accurate feedback on professional values and behaviours” (Fitzgerald, et al., 2010, p. 161). If this is the reason for the rather neutral comments on the student CPAFs in the current study then it is a concern.

The lack of written feedback for students may not be a particular problem if, as discussed earlier, all clinical teachers gave the students verbal feedback at the time of being given their CPAFs, however it was not borne out by student comments:

I think my last, possibly my last two placement I've just been give it [the CPAF] and said there you go, not even a chat about it or anything, so sometimes if it is verbal then its good but I found in the past not everyone chats to you about it, as long as they have written on it and signed the end, the last page, they're happy (FG1).

Other students had similar experiences; ‘*I didn't really have much feedback*’ (FG2) and ‘*mine just said good job, and that was it, I didn't get anything constructive*’ (FG2). Some students indicated they were proactive in seeking feedback from their clinical teachers as here;

I generally like to ask my teachers half way through and say what is it you think I can improve on ... they [are] generally pretty good they'll say this is what I think you are lacking in or you can do better in ... and they'll explain it to you (FG1)

However not all students appear as proactive as this.

Recognising feedback

One of the reasons students made comments such as those above was that they did not recognise that they were being given feedback by their clinical educators. The finding is consistent with previous research; “Learners often state that they receive little feedback, whereas educators report consistently giving feedback” (Gigante, et al., 2011, p. 206).

This was recognised by one of the clinical teachers, who said;

Feedback is also [a] very important thing, our students often don't think they're getting feedback because it's given in an informal situation or its given on the run, so I think we need to, we don't need to formally give feedback but we need to make students recognise they're getting feedback (CT4 Second interview).

Evidence that students may not recognise that feedback was being given was also found on the CPAFs. For example “[name] would benefit from planning his care in relation to his assessments and with an ongoing assessment he already does this with his buddy nurse but needs to start doing this more independently” (4 cpaf CT1-1 Nov). If this feedback was not clearly pointed out and discussed with the student the student may well have missed the comment or understood it as being what he was able to do rather than an indication that he needed to improve. With regard to verbal feedback, Gigante et al. (2011) suggest that to overcome the problem clinical teachers could use “the phrase, “I am giving you feedback”. Specifically using the word “feedback” helps the learner recognize the intent” (p. 206).

Comments without evidence

Part of giving good feedback is to “Provide concrete examples of what the learner did well and what the learner could improve” (Gigante, et al., 2011, p. 206). In this way students can identify why they received the comment and learn from this. In the previous chapter it was noted that there were a high number of comments coded as ‘comments without support’ on the CPAFs collected, but that as the collection of the CPAFs continued the number of comments coded as such decreased. A review of the coding process did not identify the process as the reason for the decline. Therefore the content of the clinical teacher workshops was considered for their influence on changes to comments made by the clinical teachers. In the workshops held prior to collecting the first two sets of CPAFs there had been sessions on the clinical challenge process and professional issues and assessment. However, these sessions seem to have produced no change. In the workshops prior to the third and fourth set of CPAFs collected there were sessions on failure to fail and the affective domain/professional practice. There is no evidence to say that this was the cause for the drop in the unsupported comments from a high of 19 in the second round of CPAF’s

collected to a low of 4 in the third round (although it should be noted that less novice CPAF's were collected in this round) therefore it is not possible to conclude that the workshops alone contributed to the change.

Students requiring more time

The difficulty clinical teachers have dealing with a student who takes more time was identified in both interview data and workshop reports. This causes the clinical teacher to increase the amount of time they spend with these students to closely supervise and assess them. As was noted in one of the workshops "... *this takes their time away from the other students who then miss out on experiences/supervision*" (August 2007 workshop report) and this from one of the clinical teachers talking about a problem student; "*you don't even see the other students ... you're stuck in [one] ward all the time*" (CT3 First interview). As a result, other students may miss out on the support of the clinical teacher. This has been commented on in the literature, for example "the impossibility of clinical instructors' capacity to observe all students' activities" (Tanda & Denham, 2009, p. 145) as a problem for clinical teachers. This was seen as an equity issue: "*you're running up and down stairs all day and ... I suppose providing the equality across the board to all of them, some ... just get a little bit less than others ... if they appear to be a little bit more efficient*" (CT2 First interview). The important thing is that the students' learning needs are met. The need to more closely monitor a student may be due to many reasons. However, it would be a strong indicator that they were not performing to an appropriate standard in any of the learning domains. Often students who are poor in one domain are also poor in two or all three.

One possible solution was suggested in the August 2007 workshop scenario, where it was suggested a failing student is assessed by an academic member of staff. An advantage with such a process is that the student is being evaluated by two different assessors, something that is not always possible where a clinical teacher is the only one at a clinical venue. Generally only one clinical assessor is available for each clinical placement and there is very little discussion in the literature around a second assessment of failing students. One paper from Bournemouth in the UK is an exception; the authors discuss "second marking"

of students on clinical placement although it is indicated that this does not always occur (Scammell, Halliwell, & Partlow, 2007).

A disadvantage though is where there are a few students who needed such assessment. Such a process could be very time consuming for the unit of study coordinator and assistance may be needed. An example is where there were three students to be assessed in such a way and only two days left of the placement. Another problem may be that the student can 'put it all together' for that one shift. Particularly so with an issue that is not psychomotor and is either cognitive, which they could 'brush up on' the day before or affective in nature.

This may also affect the relationship the clinical teacher has with ward staff as outlined by the following comment regarding a student requiring more time: "... *because it [dealing with a student] is very time consuming ... it takes time away from my other students, and it sometimes gives a very negative picture to the clinical setting*" (CT3 First interview). The negative picture here being that other areas do not see the clinical teacher and therefore feel support is not being provided to the students in their area. The concept of knotworking is also relevant here as the clinical teacher has to make choices, often on a minute to minute basis, of which students to spend time with and which ones can be left for a while. It is not only the students' needs that need to be taken into account but the amount of support the buddy nurses or ward staff are giving the students as some are much better than others. The absence of the clinical teacher can also have a negative influence on the way a ward and its staff see and support students. Due to these many factors the clinical teacher is in a constant state of re-tying the knot of contact with students and ward staff.

Summary

This section has discussed the education aspect of the clinical teachers' role. Clinical teachers teach the students in several ways by offering more knowledge to students, to demonstrate if needed and to make the link between theory and practice. For this to be effective the clinical teacher must interact with the students and the buddy nurses they are working with. To demonstrate relates to the psychomotor domain in particular while linking relates more to the use of the cognitive domain. The affective domain was not

raised by the participants in relation to the educative role. Feedback was also identified as an important aspect of the role to give the student direction in their studies. To be able to do this the clinical teacher uses various techniques, questioning and challenging the student to understand what they already know. Feedback though was contentious, the clinical teachers though they were giving feedback while students often did not recognise they were getting feedback. A further issue for the clinical teachers was the time they needed to spend with a potentially failing student and how this possibly disadvantages their other students where the clinical teacher needs to support, teach and assess the student. There is more overlap with the assessment role in this area as the questioning and challenging are also techniques used in making an assessment of the student.

Assessment role of the clinical teacher

The third role of the clinical teacher is the formal assessment of the students which with the educative role, would have been seen as part of the traditional role of a clinical teacher. In the educational role clinical teachers need to have an understanding of the students' knowledge and skill levels to be able to build on these through that role. To do this they need to make assessments of the students. These are the formative and ongoing assessments the clinical teacher makes and which have been mentioned in the educative section regarding feedback. The summative assessment role was the most problematic of the three areas for clinical teachers and students alike. There were many issues identified and few positive comments made. Problems with assessment have been discussed in the literature (Finn, et al., 2000), related to the issue of 'failure to fail' (Duffy, 2003; Jervis & Tilki, 2011) and identified as part of the preparation needed for new clinical teachers (Kilminster & Jolly, 2000). The issue is not helped by a finding that "there is limited information and even less research that describes how clinical nursing faculty determine students' clinical proficiency" (Hall, et al., 2010, p. 156).

The following points will be used to discuss the assessment aspects of the clinical teacher's role:

- Making an assessment
 - Observing and questioning
 - Feedback from the venue staff

- Variation in assessment – Objective versus subjective aspects
- Assessment forms and failure to fail students
- Graded assessment
- Work required of students
- Assessing the affective domain

Making an assessment

The following sums up the views found in the literature regarding student assessment in nursing and the clinical field: “The assessment of ... [students] in clinical practice presents a multitude of problems and is an issue that will not be easily resolved” (Nicholson, Gillis, & Dunning, 2009, p. 74). The authors also comment that there is a 40 year history of attempts to develop acceptable tools for assessment of clinical practice (Nicholson, et al., 2009, p. 74). It is usual in nursing for a single assessor, be they a clinical teacher or educator, faculty member (American term) or mentor (UK process), to make the assessment of a student’s placement. In particular this can lead to comments about the form of assessment being a subjective process, a point that will be discussed in depth shortly. This is supported in the literature, for example; “Clinical grading is more subjective and the responsibility falls on one individual faculty member per clinical rotation” (Hall, et al., 2010, p. 156).

Observing and questioning

To be able to assess students’ actions it is necessary to observe them. In talking about the process of nursing care one team of researchers described it as “direct faculty observation of patient procedures ...” (Hall, et al., 2010, p. 157). This was also identified by two of the clinical teachers, who commented “... *you need to actually observe ... [the students] and work with them*” (CT4 First interview) and “... *so you really have to be around a fair bit to keep an eye [open]*” (CT 1 First interview). It was also found in the student focus group comments where one student commented “... *because some are observey*” (FG 2) implying that the clinical teacher is there watching much of the time, and that the clinical teacher should “... *be coming and looking what you’re doing before they’re judging you*” (FG 5).

A second way to understand what a student knows and can implement is through asking them to explain their actions. There appeared to be very little acknowledgment that this happened, other than a few comments from both student focus groups and clinical teachers. In one student focus group it was reported that a clinical teacher said “... *we’ll just chat about it and things*” (FG 1) and one clinical teacher stated that “... *this particular person I was asking questions*” (CT2 Second interview). A third source of information is the nurses with whom the student is working, when not with the clinical educator.

Feedback from the venue staff

It is important for the clinical teachers to maintain good communication with the ward or venue staff as they can assist the clinical teacher in their assessment of students. In a discussion about communication, one clinical teacher commented that it was important ‘... *to communicate with the staff because they're your eyes and ears when you're not there ... if you can establish a fairly good rapport with them ... they'll be honest and let you know what your students are up to*’ (CT2 First interview). As mentioned earlier in the education section, if there is a student requiring more of the clinical teachers time which may affect the relationship the clinical teacher may have with ward staff. The ward staff may feel that the clinical teacher is not supporting the students on that ward, which in turn may affect the amount and quality of feedback to the clinical teacher.

Other participants raised a note of caution about making use of feedback from the venue staff:

... occasionally you find that some of the feedback is mischievous and you find that its mischievous because they don't get on well [with the student], so you got to be able to judge that, so you really have to be around a fair bit to keep an eye [open], and talk to the staff they are working with, and you have to unfortunately sort of make a value judgement of whether you actually will take on board what they say or not because it's not to the students benefit ... they might not get on well personality clashes, ... lots of shades of grey (CT 1 First interview)

and

so you need to actually observe them [the students] and work with them, you can't just go ... off hearsay of what other registered nurses have said about them when they've been working because sometimes that's not always an objective opinion (CT4 First interview).

As seen in these responses some of the clinical teachers felt that they needed to review students for themselves as they could not always rely on feedback from venue staff. Tanda and Denham (2009) recognise the lack of time to assess students and talks about “Clearer communication and collaboration” (p. 146) between clinical educators and clinical venue staff. However, these authors do not address this from a feedback on student progress or assessment but more in line with what has been described here as the facilitation role as they talk of “appropriate clinical activities and use of clinical sites” (Tanda & Denham, 2009, p. 146) as the focus of the communication.

Variation in assessment – Objective versus subjective aspects

Whilst clinical teacher 4 emphasises that they are looking for an objective opinion about a student, an alternative view is that much assessment is subjective:

Classroom examinations and quizzes have more objective criteria for evaluation ... and written assignments and projects often have predetermined grading rubrics ... [however] Clinical grading is more subjective and the responsibility falls on one individual faculty member per clinical rotation (Hall, et al., 2010, p. 156).

Some of the problem may come from the use of a single rater. In a study of the use of a scoring rubric in theatre nursing the authors stated “The inter-rater reliability of the instrument was greater when the average ratings of assessors were used to calculate the reliability rather than the individual rating” (Nicholson, et al., 2009, p. 81) although Hunter and Docherty (2011) found that even after three meetings to discuss and compare grading of assignment papers there were still some variations between markers.

The problem, if one can call it that, lies in a statement by Sadler (2005); “At the very heart of all grading processes, criteria-based included, lie the professional judgments of

university teachers as to the standards that are employed” (p. 189). This is particularly so in the clinical field as care provided is not binary, present or absent but as Sadler (2005) notes “There are almost always matters of degree. Furthermore, in many instances they interact with one another in the sense that changing one property may inevitably cause changes in other properties” (p. 189). Within clinical care no two patients present exactly the same therefore no assessment can be identical to another such as a written question can be. Walsh and Seldomridge (2005) provide support in that no two assessments can be the same as “the nature of clinical experiences is such that no two are alike nor can their outcomes be exactly predicted” (p. 166). Hunter and Docherty’s (2011) study was to “confirm the existence of tacit beliefs about assessment standards and their effect in generating marker variation” (p. 110). They believed that tacit beliefs were more difficult to change, that a process of briefings is ineffective in these cases, and that a “*socialisation* process [is] the most effective method to facilitate the transfer of tacit beliefs” (Hunter & Docherty, 2011, p. 111 Original italics). The use of clinical teacher workshops is the ideal place for this to occur as these allow the clinical teachers to interact with each other allowing a socialisation process to occur, thus becoming a ‘community of practice’. A community of practice is said “to be a close-knit group of workers sharing knowledge, tasks, [and] activities ...” (Hodkinson & Hodkinson, 2004, p. 23).

Assessment instruments and failure to fail students

There were many issues raised about the assessment forms and completing them, both from the clinical teachers and students. An issue for the clinical teachers is the time it takes to complete them. One expressed it in the following manner:

... honestly I struggle with filling them in, in terms of with time because I don't like to use the time at the clinical agency, because I feel, it's not a waste of time but I feel my time can be better spent working with the students so what I'll do is I will discuss it with them, I'll go home and I'll write it up (CT 4 First interview).

And from another clinical teacher, about a group they had just finished supervising: “*I still haven't finished – they're expecting theirs in the mail because they're so long winded*”

(CT3 First interview). Some universities have much shorter documents, thus making them easier and less time consuming to complete:

... have you seen the appraisals from [another university] ... one page, an A4 sheet of paper, they've got this much space for a comment on the bottom [gesture with hand – about a quarter of an A4 page] and you're thinking, get your assessment done but what actually do you want out of it, you're not going to achieve anything, you achieve ticking the boxes but you're not achieving anything for the student (CT 4 First interview).

This latter comment, “*you're not achieving anything for the student*” (CT 4 First interview) is possibly an indication that this clinical teacher recognises one of the other roles, that part of the role is educative, and that using a form such as this allows very little written feedback to be given to the student, as was discussed earlier.

Problems with the use of assessment tools have been identified in the literature. In one study “71 per cent ... of respondents ... [did] not feel confident using the Clinical Performance Indicator assessment tool ...” (Finn, et al., 2000, p. 138). Tanda and Denham (2009) have commented on assessing students' interactions with patients and issues with evaluating the quality of these interactions due to a “lack of clearly established clinical performance standards” (p. 145). A further reason given is an inability to observe students consistently, something previously discussed in this section. These issues are cited as one of the reasons for failure to fail students (Brown, et al., 2007; Jervis & Tilki, 2011; Luhanga, et al., 2008a, 2008b). Failure to fail was not raised by the participants in the initial interviews, although it was identified as a problem with attention given to raising clinical teachers' awareness via a clinical teacher workshop. Some of the clinical teachers in the workshops believed the assessment tool was “*not specific enough*” while others stated that they had “*Difficulty articulating the problem*” (August 2008 Clinical Teachers workshop). This has been identified in the literature (Finn, et al., 2000; Tanda & Denham, 2009). If the clinical teachers are able to clearly describe the level of practice of a student, this will assist in the process of failing a student, as there will be clear evidence as to why a particular grade was given. Gaining support from the academic coordinator is one avenue of help that a clinical teacher could use in this instance; however this was identified by

some as problematic, “*you’re trying to [get] in contact with the Uni and nobody is answering their calls*” (CT3 First interview).

In the CPAFs collected after the workshop where failure to fail was incorporated as a session there were less unsupported comments made on the assessment documents. This suggests that the session on failure to fail produced a desired outcome. There is a move towards a new national clinical assessment tool for nursing (Crookes et al., 2010). However, it is mainly a ‘tick box’ document with only half a page for written comments. Whether this will make this aspect better or worse will not be known until there have been extensive trials of the tool.

Graded assessment

The Bondy scale used for grading the student is also problematic for the clinical teachers, particularly in working out where a student is graded and thus providing consistency between assessors. Participants commented: “*It’s very difficult to place them into that particular category, because they might be that category ... on a part of their skills and that category in another part of their skills*” (CT2 First interview) and “*the Bondy scale is great, my only qualms with it is that ... it’s very subjective, the clinical teacher, like what she thinks is going to be different to [what] another clinical teacher thinks*” (CT3 First interview). Another clinical teacher commented:

People don’t understand about the Bondy scale in terms of what their students [can do], because they’re expecting to get fours and fives in terms of being expert but they don’t understand it’s within their scope of practice’ (CT4 First interview).

This would support the previous views about variations in assessment and how there can be a variety of professional judgements made by different assessors. It also elucidates the previous discussion on subjectivity and objectivity in assessment. To help overcome these differences, a session on the Bondy scale was incorporated into the penultimate workshop.

The students were also aware that there were variations between clinical teachers and the way they assess. One article from dietetics reported that “67% [of respondents] felt there

were inconsistencies in portfolio assessment by different supervisors” (Brennan & Lennie, 2010, p. 133). It may be that “The acts [nursing practice] are examined in a more global manner and are not broken down into discrete components with assigned point values” (Walsh & Seldomridge, 2005, p. 166). Variation in assessment and subjectivity in assessment appear to be involved here.

Difficulties in relation to assessing with the Bondy scale are possibly due to misunderstandings about its application. This was confusing for the students, as some were using the scale to try to gauge their level of attainment. One student expressed it so; “*one placement you will just pass because the teacher won’t do fours [the highest score on the scale] the next one you’ll fly through it so you have no indication what your competency is*” (FG1). Another student group showed confusion in the area:

Yea, so that was one, one big thing that everyone’s queried every placement so far (FG2) [and] you know some people who have got close to forty on placements whereas others have got, you know close to thirty ... it’s just because their educators assessed differently (FG2).

This situation was particularly worse for the second year student groups interviewed, as during their course the clinical mark was a grade based on their Bondy score. They felt aggrieved by the inconsistency: ‘*I want an HD, I got HD’s last year and I want HD’s this year*’ (FG5).

Work required of students

The students find there is inconsistency in the work the clinical teachers require as part of their assessment. Although the unit guide and the briefing sessions in the clinical teacher workshops give details of what work is required of the student on the placement, the clinical teachers were not always consistent in applying these. A student commented; “*yea it’s been ... [variable] across the three years, whether we have to [do] a care plan every, every placement others we have to do a reflective journals every placement*” (FG2) while in other cases there appears to have been extra work: “*you find some teachers ask you to do extra work on top of what you are already doing*” (FG1).

In some of the clinical units, at the time the research was conducted, part of the assessment requirements were to produce a care plan or reflective journal which is then presented to the clinical teacher. These would be read by the clinical teacher, feedback given, and formed part of the clinical assessment. These documents were intended to give insight into the students' depth of understanding of nursing work being undertaken in that particular unit of study. They became part of the clinical teachers' repertoire for assessing students.

Assessing the affective domain

One of the questions asked of clinical teachers concerned problems they encountered with second year students. The question was specifically targeted to second year students so that the data could be compared to the CPAFs collected as part of the study. Some of the issues identified in the interviews came from the affective domain, in particular regarding attitude.

However, when the CPAFs were analysed, attitude and attendance issues are not mentioned to any extent. Instead the comments are more about communication, accountability and seeking help. Generally the reports are couched in positive terms, for example: “*** *has wholly understood what was expected of her during this placement*” (4 cpaf CT1-4 Nov) and “*Seeks appropriate supervision and treats patients, families, colleagues and nursing staff with the utmost respect*” (4 cpaf CT3-1 Exp). Judging by the way these problems were seen as issues for the clinical teachers in the interviews there could have been an expectation that they would be common issues and, given the number of CPAFs collected and reviewed, the issues would have featured more. It is possible that the discrepancy occurred as it was identified by the clinical teacher in the interim (formative) assessment and fed back to the student as part of the process. Following feedback, students had possibly amended their behaviour, and consequently it was not reported in the final (summative) assessment. A further possibility is that clinical teachers do not want to be seen as critical of students, so do not mention these issues in the documents. This is consistent with the literature on failure to fail (Duffy, 2003; Jervis & Tilki, 2011). Alternatively, as discussed above, the teacher may have actively avoided recording negative comments on the CPAFs, which are used when students apply for graduate year programs.

Summary

The assessment role is a key role, as without assessment the clinical teacher is not able to identify the learning needs of the student or arrive at a summative evaluation of the student's performance to meet the university grading requirements. In assessments all three of the learning domains must be assessed. However, it appears that the most difficult one for the clinical teachers is the affective domain. There appears to be a difficulty in articulating a problem with students on the assessment documents as well as concerns about these documents and the time needed to fill them out. For students, inconsistency of assessment was an issue while for some of the clinical teacher participants objectiveness versus subjectiveness was an issue. Being able to use the facilitation role to arrange suitable experiences for the student or the education role to further help the student's development in formative ways is also necessary in particular when formative assessment is carried out.

The development of the clinical teacher

In this section the development of clinical teachers from a competent clinical nurse to that of a competent clinical teacher is addressed based on the data gathered in this study. Figure 3 presents a way that, from the data collected in the study, this development has been conceptualised. It needs to be recognised that this is not a “new” model as such, rather the way a way of representing how clinical teachers do develop as seen from the data in this study. This is a different way of presenting this understanding as well as linking it to Benner’s concept of novice to expert (1984) and may therefore be able to have an impact on ways of developing new clinical teachers.

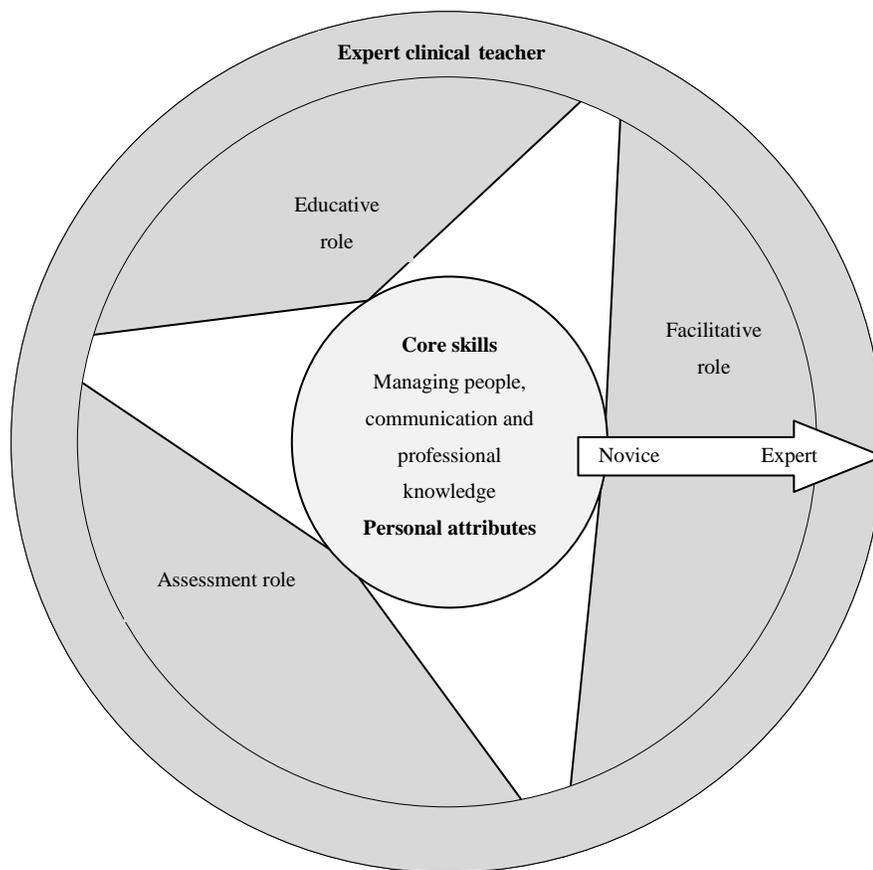


Figure 3

The development of the attributes of a clinical teacher from a clinical nurse and novice clinical teacher to an expert clinical teacher

Central to the model is the group of core skills that are required by nurses and form the hub of the clinical teacher's skills. As these skills are used differently in the clinical teaching role, they must be developed to become the skills needed by a clinical teacher. In the model the three roles of the clinical teacher identified by the research become the spokes of the wheel. As these develop an outer rim forms, becoming the rim of the wheel, showing the movement from the role of a clinical nurse to that of a developed clinical teacher. The white space is unknown information and undeveloped skills, which as the new clinical teacher develops decrease, until they are eventually an expert clinical teacher. The novice to expert arrow indicates the direction of movement and will be addressed later. The discussion will now turn to the preparation of clinical teachers.

The preparation of clinical teachers

There is no requirement in Australia, in undergraduate nursing programs, for clinical teachers to have any formal education in teaching. Interestingly, in Australian Certificate IV and Diploma courses (those leading to registration as an Enrolled Nurse) there is a requirement for assessors to hold a Certificate IV in Workplace Training and Assessment. Within that course there are modules titled 'Assess competence', 'Plan, organise and facilitate learning in the workplace' and 'Provide work skill instruction' which would be skills that could be used by clinical teachers. It should be noted, however, that the qualification is at an Australian Qualification Framework (AQF) level 4, while degree students are working towards a qualification at AQF level 7 (Australian Qualification Framework Council, 2011). At AQF level 7 there is a higher expectation of understanding in the theoretical level of content. Therefore it could be questioned if a level 4 qualification is appropriate. It is worth noting that in the United Kingdom "sign off" mentors (mentors who "sign off" that the student is ready for registration) are required to undertake further mentor education to perform the role (Nursing & Midwifery Council, 2008).

Of the participants, four of the clinical teachers reported being in a preceptor role at some point in their career prior to becoming a clinical teacher. It was viewed as being useful when they became clinical teachers, for example *"I've been preceptoring students already from [university name] and I thought that, ... it's not much different ... in being a teacher"* (CT5 First interview). Many hospitals do have training for staff members who become

preceptors. However, there are many different interpretations of that role. In the second round of interviews participants were asked how new clinical teachers could help prepare themselves for the role. It was interesting to note that none of the participants mentioned being a preceptor as part of that preparation. It could therefore be questioned if in fact this form of development is of assistance.

Another factor is the transient nature of clinical teachers. It is noted that only one of the participants interviewed as clinical teachers in the first round interviews was still working as a clinical teacher for the same institution in the follow up interview. Of the remaining participants a second was working as a clinical teacher for another institution and the remaining two had employment in educative roles, not as clinical teachers. Details are not known regarding the other two participants not interviewed in the second round, as they were no longer working for the institution the research was conducted in at the time of these interviews and no contact details were available for them.

The transient nature of their work creates difficulties for the preparation and ongoing development of clinical teachers, in particular if carried out 'in-house'. Material suitable for experienced clinical teachers may be too 'in depth' for novices and vice versa. In the September 2009 clinical teacher workshops, a mixture of novice and experienced clinical teachers was used to advantage in an education session entitled 'A day in the life of a Clinical Teacher'. In the session the clinical teachers were placed in small groups and asked to address a question. *"Each of these four groups [had] a mixture of experienced clinical teachers with at least one, but up to three, new or novice clinical teachers"* (Sept 2009 workshop notes). The rationale for creating a mix of clinical teachers was that the experienced clinical teachers would be able to pass on information and tips to help novice clinical teachers perform better in the role. In addition, the session acted as an introduction to what is expected of a clinical teacher through the questions the groups were asked to address.

The use of a novice and experienced clinical teacher working together in the clinical area was noted by one of the interviewees: *"I've been very fortunate the ones that [I] have gone out ... with on the opposite shift have been experienced clinical teachers ... and they've ...*

sort of taught me quite a lot” (CT2 First interview). This is a form of informal mentoring, a practice mentioned in the literature as supporting new clinical teachers (West, et al., 2009). Participants mentioned aspects of networking with clinical teachers collegially in their interviews; *“It is actually a good time to catch up, ... I like the workshops”* (CT3 First interview) and *“it provides an opportunity for the clinical teachers to meet, and possibly just informally to discuss issues that they have had and, and I suppose brain storm a few things as well”* (CT4 First interview). Through networking clinical teachers gain support from their peers, rather than through formal processes. Networking also allows for the socialisation around assessment standards discussed by Hunter and Docherty (2011). The reasons for this are put succinctly by Smith (2012) in a paper on assessment moderation:

Assessment is a subjective activity thus a shared understanding among assessors about what these mean for practice and opportunities for assessors to engage in discussion, debate and ongoing interactions to share views will assist to address ... issues in grading (p. e46).

Price (2005) discusses getting together to share information in this way with the concept of ‘communities of practice’. The use of the term community is also found in other writers in this context. Bloxham (2009) talks of “the creation of an assessment community amongst marking teams” (p. 212) and Smith (2012) talks of “communities of assessors who are there for a common purpose of reaching a shared understanding” (p. e46). These groups would fit with “examples given by Lave and Wenger, [where] a community of practice appears to be a close-knit group of workers sharing knowledge, tasks, [and] activities ...” (Hodkinson & Hodkinson, 2004, p. 23) and provide strong support for workshops for clinical teachers.

Such processes can also help the clinical teacher develop expertise through listening to other clinical teachers talking about issues they may have encountered and how they overcame them. This will help the newer clinical teacher think about and reflect on their own practice, one way of developing expertise and thus moving along the novice to expert continuum.

Information about the role and expectations

A lack of information was seen as an issue for the clinical teachers. For the novice clinical teachers it included what was expected of them and knowing the university processes. It was linked to the lack of preparation for the role, as identified here: *“I didn’t know about clinical challenge² ... I was never told that I could actually put a student on clinical challenge, so I didn’t know my boundaries as to how far I could [go]”* (CT2 First interview). For experienced clinical teachers it was more about knowing about changes to policies and processes and the way they needed to deal with student issues. The latter aspect was surprising, as the clinical teachers are expected to attend the workshops where these issues are discussed. If they do not attend, they are all sent, at the start of each semester, a pack containing the updated documents to which they can refer if necessary, and which include new or updated forms.

Over the course of the data collection the number of briefings on the clinical units had decreased to none. This may have accelerated the problems with clinical teachers not knowing expectations of unit of study coordinators for that placement. The outcome of lack of information may be that students could be asked to do something for which they had not yet been prepared. This was discussed earlier in relation to Assessment.

Having knowledge of expectations and the topics students have been taught during the concurrent academic units will help the clinical teachers in making the best use of the clinical experience for the students. It includes matching practice to recent theory or skills taught in a clinical laboratory setting. One clinical teacher in particular did comment that their role as a teacher in laboratory sessions at the university helped prepare them for knowing what the students had, and had not, been taught prior to the students’ clinical placement. There were also comments which described students avoiding practicing skills in the clinical placement that they claimed had not been taught to them at university. From the laboratory teaching the clinical teacher knew that the skills had been taught and so could challenge the student:

² See glossary for information on a ‘clinical challenge’.

... out there they're saying no we haven't done that we haven't done that ... and I know now that they have and they won't get away with that with me any more (CT2 First interview).

A second participant also referred to the significance of teaching in the laboratory sessions. However, it should be noted that not all clinical teachers are employed in such positions; therefore not all have the advantage of this knowledge. However, if this did occur it would help the clinical teachers to be aware of the students' current knowledge level. As an alternative, it is suggested that the clinical teachers could be given a copy of the related theory unit outline, ensuring some understanding of what was being taught to the students. The document could be supported by a briefing from the clinical unit of study coordinator at a workshop timed before the commencement of the placement, enabling questions to be answered and issues clarified. Laboratory work is aimed at increasing the students' psychomotor skills along with some cognitive domain development. For difficulties arising in the affective domain, a briefing by the clinical unit of study coordinator would be most useful.

Novice to expert

Benner's (1984) concept of 'novice to expert' can be used to understand some of the comments made by participants and the analysis of data in relation to clinical teachers. Benner (2004) describe five levels of practitioner: Novice, Advanced Beginner, Competent, Proficient and Expert. Benner describes the novice as being rule driven as they have no experience so need to rely on rules. Benner's "expert nurse [is one] whose intuition and skill arise from a comprehensive knowledge base thoroughly grounded in experience" (Burket et al., 2010, p. 370). On this basis, expertise is developed through both expanding knowledge and experience. This can be problematic though as discussed later many clinical teachers do not stay in the role for long, there being reports of many with less than two years experience; thus they do not have time to develop the experience needed to be called an 'expert'.

Examples were found in the interview data that are consistent with identifying a clinical teacher's level of expertise. For example: *'I just find ... people are out there flying by the*

seat of their pants and they're not really knowing what's expected and what the standard ... [is]' (CT 2, 2nd interview) illustrates the way a novice will be working. This finding is consistent with Scanlan (2001, p 243) who identified that clinical teachers flounder when they start, having little direction or support. In contrast, an expert clinical teacher can recognise subtle clues, for example the following which may indicate a student who requires questioning to reveal their true knowledge level:

... this particular person I was asking questions, she actually ducked behind another person, "don't do that I said, that's making it more obvious", ... they do they fly under the radar and I just think sometimes maybe some of the other clinical teachers, who haven't got as much experience may not be identifying and challenging these people at that point; (CT 2, 2nd interview).

Expert clinical teachers would also be expected to make greater use of pedagogical content knowledge or PCK (Shulman, 2004a, 2004b). This is the use of pedagogical or teaching knowledge to be able to effectively convey to the student the content or nursing knowledge they need to know or where “pedagogy and content are completely intertwined” (Chick, et al., 2006). Novice teachers are more likely to concentrate on content while experienced teachers will incorporate more pedagogical knowledge along with content knowledge in the written comments and feedback given to students. Novices show a greater focus on quantity while experts focus on quality (Jones & Moreland, 2005). In the CPAF analysis it was noted that comments by experienced clinical teachers tended to be more individual and less repetitive of the information on the forms. The novice teachers tended to concentrate on telling the students what they may have done wrong with little advice on how to improve, while expert teachers were more likely to guide students on how they can improve. This can be quite clearly seen in Table 14 (p 112) where it was noted that experienced clinical teachers made two to three times more comments with explanation than the novice clinical teachers did. These differences can be seen in other ways. For example, the novice clinical teacher talked about ‘demonstrating’ to students, a low or surface approach to teaching and only using content, compared to the clinical teacher who ‘challenged’ students, aiming more for a deep approach through using pedagogical techniques (questioning) to improve learning.

Intuitive knowledge is often used by experienced nurses when “judging competence and safe practice” (Paliadelis & Cruickshank, 2003, p. 7). Paliadelis and Cruickshank (2003) comment that “tacit knowledge is used unconsciously by assessors of clinical performance and is therefore difficult to articulate” (p. 4). As a result assessors may have difficulty documenting their tacit knowledge, thus accounting for superficial comments on the CPAF forms. Another reason for brief statements in these documents may be due to the length of time it takes to fill the forms out previously identified.

Turnover of clinical teachers

In the second round of interviews only one of the original participants were still working for the same university. One had taken clinical teaching work with another institution and two others had taken up other education roles relevant to their particular expertise. The remaining two original participants were no longer contactable therefore it was not possible to know how or if they were currently employed. This is indicative of the turnover of clinical teachers that is seen in Schools of Nursing however the reasons for this are not explored in any depth in the literature. One study reported that only about one third of the participants had worked for the same institution for over two years and over half had less than two years experience, thus supporting a significant turnover rate (Whalen, 2009).

Whalen (2009) identified several factors that the participants found stressful. These included dealing with failing students, too many students, “Poor communication or relationships with agency, staff, & students” and not being prepared for the role (pp. 10 - 11). An additional stressor was identified by Fenwick (2007) who stated that some people find the loose connections of relationships identified in Engeström’s (1999) knotworking very stressful, thus causing novice clinical teachers to discontinue the role. In Fenwick’s study she reported parents and teachers who left as they wanted “more programme and policy structure, more written documentation and accountability” while “an administrator left, citing frustration in the lack of order” (Fenwick, 2007, p. 145), therefore if the clinical teachers feel this way then they are likely to leave the role. A further stressor is that clinical teachers are employed on a casual basis. There is therefore no permanency in such a position, with many working for more than one university or in combination with other positions to maintain full time employment or are accepting of part time employment.

Returning to the wheel diagram (see Figure 3 p. 180) it could be proposed that another reason for high turnover of clinical teachers is that the spokes on the wheel are not developed strongly. Thus one or more spokes fail, causing the clinical teacher to leave the role. This is consistent with the findings of Whalen (2009) and Fenwick (2007), which reinforces the need for clinical teacher development. This could be through education sessions in workshops, the development of mentoring programs or as are now becoming available Graduate certificate courses in clinical teaching. Whatever process is used it is clear that new clinical teachers need assistance in developing and becoming experienced ones.

Summary

In this chapter, the data from the five sources previously reported were compared and synthesised. Three themes define the key roles of a clinical teacher and identify the skills developed as they move from being a novice with core skills to an experienced, expert clinical teacher: facilitation, education and assessment. Factors that affect the work of the clinical teacher that should be taken into account when helping clinical teachers develop in the role were identified. These include: a view that a good clinical nurse will make a good clinical teacher, a lack of or poor preparation, working in isolation, lack of qualification recognition (although this is now changing), confusion over assessment documents and processes, lack of peer and academic support and the complexities of the role including working in an ever changing environment.

In the final chapter, a discussion of the implications of these findings for the development of clinical teachers will be presented. In addition, comments on the research process and suggestions for further research in the area will be made.

Chapter 6:

Conclusion and recommendations for the development of clinical teachers

Introduction

This final chapter will bring the findings of the study together and produce recommendations to aid in the future development of clinical teachers. Helping clinical teachers to develop from a novice to an expert should ensure a rewarding experience for students allocated to these teachers on placement. The work is a model study contributing to real world problems and adding to our knowledge of the particular profession.

The study stemmed from a professional interest in and involvement with clinical teaching and teachers. The aims of this study were to critically examine the factors that have an impact on how the clinical teacher is able to perform their role and to propose how an understanding of these factors can aid in the professional development of highly accomplished clinical teachers in nursing education. To achieve these aims three questions were asked:

1. What are the complexities of the practice of the clinical teacher?
2. What are the skills, knowledge and attributes of an expert clinical teacher?
3. How can an understanding of the skills, knowledge and practice of clinical teaching be used in the professional development of clinical teachers?

The findings of the study are re-presented including the recommendations arising from the findings, a self critique of the study, limitations of the study and recommendations for further research. The recommendations given here are of four types. The first are specific to the research site as they apply to the processes and procedures of that institution. These are termed local recommendations. The second relate to the content of workshops and can also be included in the next group, and are called Workshop content. The third are termed general recommendations as they may apply to most schools of nursing. The fourth apply to registration and accreditation bodies, termed accreditation recommendations.

Clinical teaching is a complex process that requires many skills of the nurses who undertake the role. Both the literature and the participants in this study indicate that at the

start novice clinical teachers often flounder, with little support and preparation provided for the role. Although they are usually skilled clinicians, further skills are needed to perform the role, which most learn 'on the job', often without the support of a mentor. Clinical teachers generally work in isolation from other clinical teachers and university academics which produces further problems.

Roles and skills required of clinical teachers

This study has identified three key roles undertaken by clinical teachers which they must develop to become an expert; a facilitation role, an educative role and an assessment role. All three of these roles will develop over time through trial and error and reflection; however this development can be accelerated through education and support programs. Some of the participants stated that mentor/preceptor programs attended prior to becoming a clinical teacher were useful in preparing them for the role. It was identified that in the United Kingdom this is compulsory although not in most other countries although, for example, in some states in the USA there are recommendations about the level of qualification to be held by clinical educators (Whalen 2009).

Local recommendation

- That all new clinical teachers are only employed after they have undertaken a mentorship/preceptorship program.

Accreditation recommendation

- That a recommendation is made to the Australian Nursing and Midwifery Accreditation Council that educators who assess students in degree programs have undergone an education program (be it a mentorship/preceptorship program or a formal qualification) prior to assessing students.

In the facilitation role the clinical teacher is enhancing the learning opportunities for the students as well as to support them both professionally and personally if needed. A further way in which they facilitate learning is through negotiation with the clinical venue staff for appropriate learning experiences and smoothing the way for the students to participate in patient care. There are indications that this does not always happen for various reasons, however it is a practice that should be encouraged.

General recommendations

- That the educational needs of students come before the service needs of the placement, given that students are supernumerary and not part of the paid workforce.
- That patient allocation to students should be discussed with and approved by the clinical educator to ensure educational needs are being met.

The loose relationships that the clinical teacher makes with the clinical staff to enhance the quality of placements were likened to those seen in the knotworking concept described by Engeström et al. (1999). Coping with knotworking can be stressful for some people although this was not one of the stressors identified in this study; however there were others such as completing assessment forms and dealing with failing students. What factors these plays in the high turnover of clinical educators was not identified clearly in this study although the three clinical teachers no longer in the institutions employ at the second round of interviews were still in educative roles, though only one in a clinical teaching one.

General recommendations

- That further research into Engeström's (1999) notion of knotworking be conducted, focussing on how this relates to the working relationship clinical teachers have with venue staff, students, and the university and the effect this may have on their continuance in the role.
- That Whalen's (2009) study from the United States on work-related stressors should be replicated in Australia to identify stressors associated with Australian clinical teachers.

The educative role involved helping the student apply their knowledge and skills to the clinical arena through demonstration and guidance, using a variety of methods of interaction and engagement. One method of understanding how much a student knew was 'challenging the student', which was identified by both participants and in the literature. This was a technique for helping the student to expand their knowledge. To do this good questioning skills are needed by the clinical teacher so that the student can see the relevance of the questions and learn from the experience.

Workshop content

- That training in questioning skills is incorporated into workshops for clinical teachers, possibly through the use of simulation sessions.

The perceived lack of feedback to students was identified as a weakness in clinical teachers' practice by the student participants. However, this finding was contested by the clinical teachers who stated that they were giving ongoing verbal feedback to the students. This dissonance indicates the need for documenting feedback for students or the provision of clearer explanations that the comments being made are feedback. A reason for not giving written feedback was identified by both groups of participants; the avoidance of what could be conceived as negative comments on documents that were used to gain later employment was offered as one reason. Another were comments about the time it takes to fill out the assessment forms, one clinical teacher commenting that they took them home and filled them out after the placement. Suggestions for how written feedback could be provided and improved were discussed. However it was also recognised that the information given on the forms was not informative as feedback or for unit of study coordinators to make an assessment of the students' actual practice.

Local recommendations

- That a process is introduced that ensures students receive feedback both at the formative and summative stages of their assessment, preferably in writing.

Practices and problems concerning assessment were explored and identified in the study. The practices included the processes clinical teachers used: observing the students, questioning the students, and by consulting clinical staff. However, feedback from the clinical staff (buddy nurses) was recognised by some as being problematic. The assessment forms themselves were identified as awkward. At some stages they were seen as requiring a significant amount of work to fill out and therefore time consuming. Being able to adequately articulate the problems when a student was performing poorly was also identified as difficult for some clinical teachers.

Workshop content

- That new clinical teachers are given advice about the nature of comments expected on the assessment forms. These comments should cover all of the three learning domains, psychomotor, cognitive and affective.

The consistency of assessment was also an issue; the students identified that different clinical teachers have different views of the level of skill required of the student, relative to the scale used to assess the students' performance. This was particularly seen with graded assessment. The clinical teachers themselves were worried about the subjective nature of assessment. This is perhaps compounded by the fact that clinical teachers work in isolation, and the assessment is made by a single person, whereas in theory units marking is moderated and second marked if the student is failing.

This information was then used to conceptualise development of clinical teachers. A wheel (see Figure 3, p. 180) was used, with the hub representing the core clinical skills of the nurse. As the nurse developed from novice to expert clinical teacher, the three roles, facilitation, education and assessment, extended like the spokes of a wheel, expanding until they reached the rim, where the clinical teacher could be considered an expert in the role. Benner's (1984) theory of development from novice to expert was used to inform this conceptualisation and the discussion of the development of clinical teachers which followed.

Preparation for novice clinical teachers

It has been identified that there is no formal preparation required for clinical teachers of undergraduate nursing students in Australia. This is not unique, as the only country that has been specifically identified in the literature as requiring specific preparation for clinical educators is the United Kingdom. In the UK assessors are required to have undertaken a mentorship program and, for the final assessment prior to registration, a second program (Nursing & Midwifery Council, 2008). There is also evidence that nursing in Australia is not alone in this. In Europe it is reported that "there is no consensus on the minimum qualifications or required experiences of educators" in nursing (Salminen et al., 2010) while a similar lack of preparation has been identified in the education field in a comparison

between Canadian and Australian school teachers (Mitchell, et al., 2007). It is an anomaly, though, that in Australia, clinical teachers who teach and assess students completing a Diploma in Nursing (required for registration as an Enrolled nurse) are required to hold a Certificate IV in Training and Assessment. It is noted that one of the participants thought that it did not help them in working as a clinical teacher. The Certificate IV takes a general view of training and assessment and if there were some elective modules with one or two directed towards clinical teaching this may make it more appropriate for clinical teachers. The other concern is that this course is aimed at lower Australian Qualification Framework (AQF) level courses than those being undertaken by Bachelor level students and that clinical teachers for degree student should be educated to at least the same level if not to a higher level.

Local recommendations

- That all new clinical teachers attended a workshop that includes outlining the requirement of the unit/s they will be teaching in and the process of assessment used.

Scanlan (2001) described clinical teachers as having little direction or support when they first start in the role, and identified that most learning was done “on the job” (p. 243). This was still the case for some of the participants in this study who are ‘flying by the seat of their pants’. This situation is possibly not helped by the lack of formal requirements to hold a qualification prior to becoming a clinical teacher; however some courses are now becoming available for those wishing to undertake them.

Having been through a mentor or preceptor program will give some initial support to new clinical teachers. Some study participants mentioned this as helping them with aspects of the role. The role of a mentor or preceptor is different to that of a clinical teacher; therefore it will only provide limited assistance. One participant identified that ‘*if I had training ... in adult teaching*’ (CT3 1st interview) this would have settled them into the role quicker. This participant identified that it took two years to become experienced in the role but did not refer to any mentor or preceptor preparation.

Some universities are now offering post graduate courses in clinical teaching. Sometimes these appear to be a single unit taken as part of another course while others lead to a qualification in its own right such as the Postgraduate Certificate of Nursing Science (Clinical Teaching) offered by James Cook University (2012). There are however issues with encouraging nurses to take up post-graduate courses due to costs although some universities will subsidise the cost of courses for staff within their own institution. In 2012 the cost of completing the Postgraduate Certificate in Nursing Education at Charles Sturt University was \$5,960 (2012) while the cost of a Graduate Certificate in Clinical Teaching from the University of Melbourne was \$9,450 (2012).

The workshops

Workshops appear to be a common way of preparing and developing clinical teachers, examples of their use being found in the literature from the United Kingdom, the USA and Australia (Bourgeois, et al., 2011; Henderson, et al., 2011; McVeigh, et al., 2009; West, et al., 2009). Workshops can have three functions, to inform clinical teachers about developments and changes that may have occurred in the course since they last worked for that university, to include educational sessions as professional development for the clinical teachers and finally to develop a community of practice where participants can discuss issues and gain support from other clinical teachers. Educational sessions as professional development were the original focus of this study and can be most useful in helping develop novice clinical teachers. For these latter reasons the following recommendation is made.

General recommendations

- That workshops for clinical teachers continue to be used as a primary method of informing and developing clinical teachers wherever possible.

In this study workshops were part of the preparation and development of the clinical teachers. For clinical teachers who cannot attend such workshops there are other means of informing them of the requirements through the use of documents related to the course and assessment or, as in one case reported in the literature, through the use of a CD-rom containing video and audio clips as well as documents (Reid-Searle & Moxham, 2005).

From a literature search which produce little material it would appear that the use of the internet or web based tools in this area has yet to be investigated.

While these other means do inform clinical teachers about the students and units they are undertaking, clinical teachers will be missing out on two important aspects that are provided by workshops. Some of the participants in this research found the networking and peer support which occur through the workshops very helpful. Being able to meet with the clinical unit of study coordinator prior to a placement may make the clinical teacher more comfortable in contacting them if there are issues while on clinical placement.

General recommendations

- That academics responsible for clinical units of study attend briefings for clinical teachers at the workshops.

In the workshops a problem was identified in finding a balance between developing the new/novice clinical teachers and keeping the experienced ones interested. One may, in catering for the first group, have to repeat material already known to the experienced clinical teachers. There are advantages in bringing novice and expert clinical teachers together. This occurred in one of the later workshops in this study where the expertise of the experienced clinical teachers was used to help inform the new clinical teachers about aspects of their work with students. In this way novices can use the information and expertise of experts to progress their development along the novice to expert path without having to experience events first hand or rely on trial and error to progress. In this way a 'community of practice' can develop with the benefits previously discussed.

The use of simulation is also worth commenting on in relation to this aspect of clinical teacher development. Simulation has been used in the medical and other fields for many years; however this seems to be fairly new in the development of clinical teachers (Krautscheid, Kaakinen, & Warner, 2008). Simulation was used in some of the workshops reported as part of this research, both through the use of a recorded simulation to aid the workshop participants to understand the Bondy scale and as an introduction to what the students would be experiencing. The use of simulation could be expanded; for example it could be an appropriate way to show those subtle features of student interactions that

clinical teachers need to understand to move them from being a novice to a more expert practitioner. An example of this is with questioning techniques where the evidence is that often low level techniques are used (Phillips & Duke, 2001). A study of athletics instructors (Barnum, 2008) has shown that a funnel technique using low level questions to start and then working towards higher level questions is more effective in developing critical thinking skills in students. Barnum (2008) comments:

... in order to promote the development of clinical proficiency and critical thinking, the instructor needs to be adept at selecting and using a variety of questioning styles and teaching strategies to better assist the student in clarifying, identifying, and evaluating information gained from experiences (p. 291).

Workshop content

- That simulation laboratory sessions are used to help the clinical teachers to arrive at a consensus on assessment levels (the Bondy scale).

General recommendations

- That further research is carried out on the use of simulation sessions with clinical teachers, in particular how effective this is in developing novice clinical teachers.

Novice to expert clinical teacher

As was indicated in Chapter 5, expertise is a mixture of knowledge and experience. The discussion of pedagogical content knowledge or PCK showed that there is the need for a clinical teacher to have both content knowledge and pedagogical knowledge for nursing education in clinical settings. In the wheel diagram (see Figure 3, p. 180) the content knowledge or the clinical knowledge required of an expert is seen as the core, or hub of the wheel.

The spokes of the wheel are the developing pedagogical knowledge related to teaching nursing in clinical settings, and the additional knowledge needed to move from the expert clinician to become an expert clinical teacher. While this knowledge is being developed the novice clinical teacher is gaining the experience which must be added to the knowledge, for expertise to be shown. It therefore follows that as more knowledge and experience is gained

the spokes get bigger, and there is less to know. However the spokes do not totally meet, as one is always learning. Therefore the gap never completely closes there is always that area of unfilled or unknown knowledge, and thus a need for ongoing professional development.

The content of each clinical teacher's ongoing professional development will depend on several factors. These which will include the extent of their development along the path of novice to expert, their own areas of strength and weakness, and changes and developments occurring in the wider clinical field that impact on their work. From the study findings and the wider literature, areas for potential development include questioning skills, giving effective feedback to students and skill in articulating and documenting areas of poor practice, in particular if they are failing to meet the required standard. These would all help in strengthening the education and assessment spokes of the wheel model.

Critique and limitations

The participants' interviews and Clinical Performance Assessment Forms (CPAF) used in this study provided rich data which were analysed for the thesis. Diversity of data sources enabled triangulation of data as findings from one source was supported or expanded upon by evidence gathered from another source thus giving depth and trustworthiness to the findings. Although not sufficient to generalise to all situations, it is sufficient to validate the findings within the school of nursing studied.

Due to changes that occurred during the conduct of the study the original study design was adapted. The consistency of the clinical assessment tool underwent three changes over the course of data collection, although the last change was to format not content. The role of myself in the clinical teacher workshops also altered from full control of content to being a participant with input. It was initially planned to use design based research to inform the content of these workshops in an iterative process. Due to different staff responsibility for the overall content of these workshops over the course of the data collection, it was not always possible to use feedback from the data collection to inform the sessions in the next workshop. Current issues were used to inform the content of the education sessions in the workshops, with some of these being identified by the ongoing data collection.

Individual interviews with clinical teachers provided in-depth data with the second interviews clarifying the initial data and its interpretation. The major issue here was an inability to return to all the original interviewees. This highlighted one problem with the development of clinical teachers; the transient nature of their employment. The use of focus groups to interview students was also effective. It may have been problematic to interview students singly; they may have felt intimidated in this case. Students were willing to talk as a group with expansive comments being made, thus increasing the depth of discussion.

Due to the variety of data collected the use of generic qualitative analysis (Caelli, et al., 2003) was beneficial. The term is arrived at from the use of a variety of qualitative techniques to support the analysis of the data (Shambley & Boyle, 2006). Such a process allowed the data to stand 'on its own' and not be aligned to a specific methodology. It allowed the data to 'speak for itself'.

Limitations

There are limitations to this study that would not enable the results to be generalised to all clinical teachers. The first is that it took place in only one school of nursing which has its own structures, processes and documents. Differences in other schools of nursing may impact on how these findings could be applied. Likewise the study took place in one state of Australia, therefore if applied to other states or countries there may be differences.

The number of participants was modest; however there was congruence between their comments, therefore data saturation was judged to have occurred. In the follow up interviews with the clinical teachers, only half were still in a clinical teaching role, with only one at the same institution. This may have affected their views and comments, especially in regard to their development in this role.

Recommendations for further research

During the current study several areas have been identified that were either not able to be explored in sufficient depth or were identified as needing further research. This section puts these forward as areas worthy of being pursued.

Using feedback from clinical venue staff in the assessment of students does not seem to be an area that is addressed in any detail in the literature, and is worthy of further investigation. The relationship between the clinical teacher and the clinical venue staff is also worth further exploration. It would seem from this study that if there is a good relationship then students can benefit. It is suggested that where there is a poor relationship, students do not gain the experience they need to develop, for example being given repetitive and basic tasks. The concept of knotworking (Engeström, et al., 1999) may be a useful construct for such an investigation.

The increasing use of clinical educators provided from venues who are clinical staff seconded to the role during student placement is worthy of further research. There is no discussion in the literature on the topic, therefore it would be useful to explore how are they prepared and whether they have the same experiences and perceptions as clinical teachers.

Peer support for clinical teachers has been identified in the current study as an area of need and thus is a topic for further research and publication.

The lack of evaluation of clinical placements, both the teaching and experiences via appropriate evaluation tools in clinical units is an issue. One important reason for the use of evaluations, linked to the earlier discussion on marking standards, can be found in the following comment:

The lack of feedback to markers on their marking seems to be a missing link in the process of internalizing standards. Such feedback would help to guide novice markers and may also alert experienced markers that they need to revisit the basis of the standards they apply. (Price, 2005, p. 227)

Final comments

The clinical practicum is a critical part of the education of a student nurse. The role the clinical teacher plays in the practicum is critical in enabling the student to contextualise and apply their theoretical knowledge to the clinical situation, thus enabling the student to become a beginning registered nurse.

Being a clinical teacher is a complex role that can be challenging to nurses who move into the task. Not only do they use their clinical expertise, but they must also develop skills in teaching to become an expert clinical teacher. Not only must they juggle the demands of the eight students they supervise, but they must also work with clinical staff of the areas to which students are allocated, as well as serving as a link between the university and the clinical area. They must facilitate the students' learning as well as provide education and make an assessment of the students, often in isolation. If all these tasks are done well, the students can gain much from their placements and show good development on their path to registration. If not, it may create problems which will be inherited by the next clinical teacher or even employers and the public at large if they get to registration.

It is important to develop the clinical teacher from a novice state to being an expert. This thesis has highlighted the need for better preparation and ongoing development of clinical educators of student nurses who are undertaking their clinical practicum. If this does not occur, then students may miss out on important development of their clinical skills.

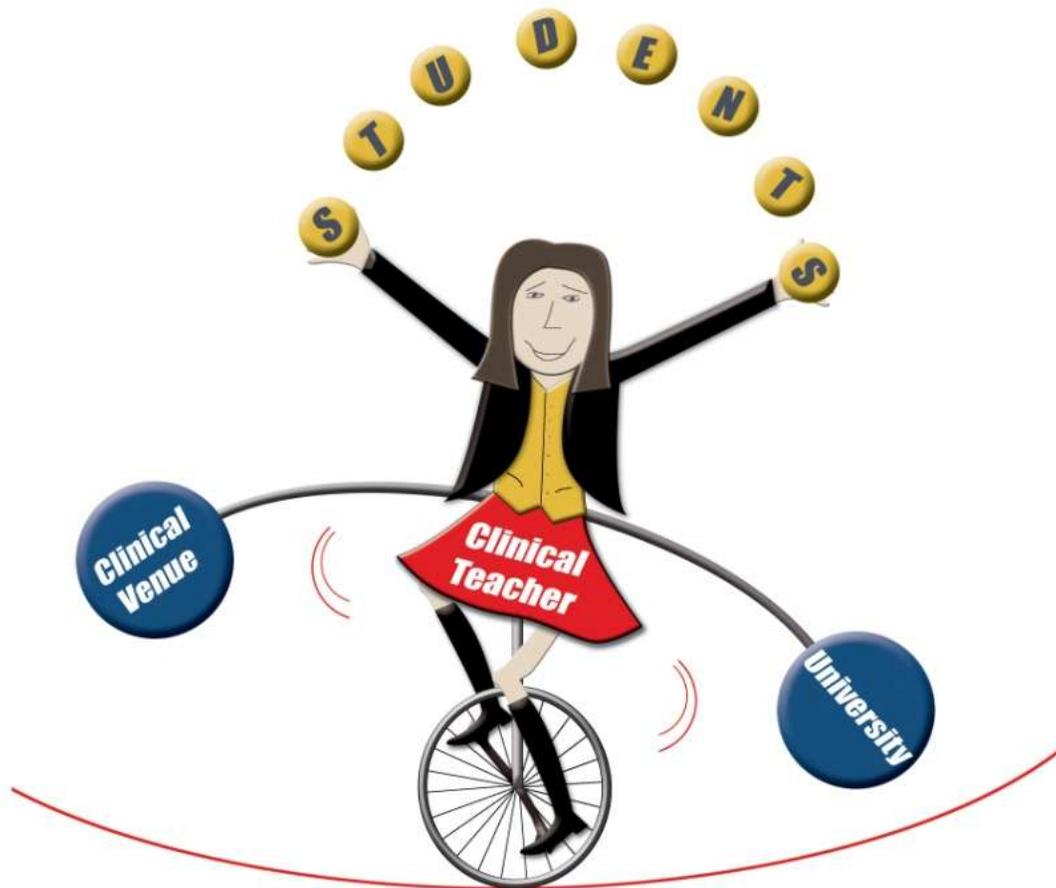


Figure 4
The complexities of the clinical teacher role – a balancing and juggling act.

The demands of the university, the profession, the clinical venue, and the students all impact on the clinical teacher. In this ‘juggling act’ it is important for there to be balance, for ongoing professional development of the clinical teachers, and the addressing of challenging aspects of the role, To quote a friend, ‘Quality begets quality’; if one has a clinical teacher who is able to give quality teaching then one is more likely to get quality student practice and subsequently quality nurses.

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Appendices

Appendix 1

Question protocols for clinical teacher interviews and student focus groups

Question protocol for the first clinical teacher interviews.

Some background questions

- How long have you been a clinical teacher?
 - a. For which universities?
 - b. At which hospitals?
 - c. For which levels of students?
- How were you prepared for the role of clinical teacher?
- What formal or informal education/training for the role have you completed?
- Do you hold any teaching or clinical teaching qualifications
i.e. Cert IV or Grad Cert?
- Do you think that clinical teachers should hold a formal qualification in clinical teaching?
If yes at what sort of level?

The role of clinical teachers

- How do you see the role of the clinical teacher?
- What helps you in this role?
- What hinders you in this role?

- What do you find difficult about clinical teaching?
- Communicating with hospital staff – how important is this to your role?
 - a. What makes it easy?
 - b. What hurdles can there be?

Student issues

- What are some of the typical problems that you encounter with students?
- What techniques do you use to deal with problem students?
- What are the common misconceptions that students at the end of second year have? (this will link with the CPAF's and PCK)
- How then do you deal with these? (*this will link with the CPAF's and PCK*)

Clinical teacher workshops

- How do you see the Clinical Teacher Workshops helping you develop as a clinical teacher?
- What sections of the workshops do you find most useful?
- What would they like to see in future workshops?
- Do you ever encounter any problems during the placements that you had not been prepared for? If so please elaborate and how did you overcome this?

The CPAF (assessment tool)

- What are your views about the current assessment tool?
- How do you think it compares with previous tools?
(If not commented on in the first question.)
(If had experience with previous tools used by the school.)

- What are your views about the use of the Bondy scale in assessing students?
(If not commented on in the first question.)

Question protocol the second clinical teacher interviews.

Q1 In the first round of interviews you told me XXX, since then what has been your experience of clinical teaching?

Q2 If you had to describe the role of a clinical teacher to somebody who was new, or just coming into the role how would you describe the role and responsibilities of this position?

Follow up questions that could be asked:

1 The role of the clinical teacher has been described as being a “preceptor”, a “facilitator”, a “mentor” and a “role model” for students. These terms are also used in other ways when talking about students and clinical placements. How do you see them being different, or are they different, when they are used when talking about clinical teachers?

Mother, or mothering, could be added to this list as there is some literature on this as well as a mention in one of the workshop reports.

2 There seems to be some “hidden” roles for clinical teachers. Giving references (being a referee for Graduate Year programs for example) for students is the example I have come across that was not mentioned in the first round of interviews. Is there anything else like this that you can think of that is “hidden”, that are not generally talked about as being part of the role of the clinical teacher?

Q3 Since we last talked have you undertaken any professional development and how has this helped you develop in the role of clinical teacher?

If they don't mention the clinical teacher workshops they could be asked how they see them fitting into their professional development

Q4 What preparation would you suggest to new clinical teachers that would help them to develop quickly into the role?

Q5 One thing to come out of the first round of interviews and supported by some comments made at the last clinical teacher's workshop was that it is useful for clinical teachers to know what the students have been taught in the theory unit. How do you use the knowledge of the theory the students have been taught in your education of the student on placement?

Follow up questions that could be asked:

1 If you do not make use of this theory what then do you use to guide the students learning in the clinical placement?

Q6a In the first set of interviews some of the clinical teachers said that clinical staff do not understand the role of the clinical teacher. How then do you go about developing your relationship with the staff so that they understand your role?

Q6b What made you adopt this strategy?

Q7 What do you find is your role in patient allocation to students? What techniques do you use if you would like a change of student allocation?

Q8 When you give the students their formative assessment what sort of information do you give to students to help them meet the requirements for gaining a pass grade in the unit?

Q9 What sort of comments do you make on the summative document that gives the student some ongoing points for further development?

Q10 Since the last time I interviewed you how do you see yourself developing in the role? What areas would assist you to continue developing in this role?

This question can only be asked if they are still in a clinical teaching role.

Question protocol the student focus group interviews.

- What do you think the role of the clinical teacher is?
- Thinking about your idea clinical teacher what attributes would you like them to have?
- What types of skills in a clinical teacher do you find most helpful?
- What types of skills in a clinical teacher do you find least helpful?
- What sort of knowledge do you think it is important for clinical teachers to have?
If necessary prompt them with suggestions like clinical skills, knowledge of the course structure (curriculum) and knowledge of the clinical area.
- Thinking back to second year many of the CPAF forms do not seem to have information on them that would give you further guidance for later units.
- Did you receive any such feedback from those clinical teachers?
- Do you think this is important or not?

Appendix 2

Programs for workshops that formed part of the data

August 2007

No programme was available for this workshop. The content, as follows is taken from the researcher's field notes of the workshop.

Update on administrative matters

Racial discrimination and cultural diversity

The clinical challenge process

Orientation to the next semester's clinical units by the clinical unit of study coordinators

February 2008

CLINICAL WORKSHOP

Tuesday 19 February 2008

9am – 2pm

Building 4, Level 3 Room 4c337

AGENDA

- | | |
|-------------------|---|
| 9.00am -10.00am | Administration (Forms, Information etc.) |
| 9.45am - 11.15am | 2007 Debriefing Session |
| 11.15am - 12.15pm | Clinical Updates (Coordinated Care, Mental Health, Acute Care) |
| 12.00pm – 1.00pm | Lunch |
| | Building 3, Nursing Lab |
| 1.00pm – 2.00pm | Bondy Scale Information Session (including practical exercise) |

July 2008

TUESDAY 29 JULY 2008

ERIC LUND ROOM – Bldg 4, Level 1, Rm 3s113

| | | |
|-------------------------|--|---|
| 9.00 – 10.30 | NEW Clinical Teachers Orientation | Carleen Abela – Administrative issues Clive Miller – Clinical teaching |
| 10.30 – 10.45 | Morning Tea | |
| 10.45 – 11 | Administrative information | Carleen Abela |
| 11 – 12.00 | Failing to fail students – what is happening? | Clive Miller |
| 12.00 – 12.30 | Lunch | |
| 12.30pm – 2.00pm | Clinical Debrief/Brief Session | Update of changes in the School including Changes to Clinical Performance Assessment Tool. Clive Miller and Karen Lawrence Briefing on second semester clinical units. Clinical unit of Study coordinators |
| 2.00pm – 3.00pm | Effective feedback | Ross Byrne, Anne Arthur & Nicole Brown |

December 2008

December 2008 Clinical Teacher workshop agenda

| Time | Session |
|---------------|---|
| 10 – 10-30 | Administrative matters (CLO staff) |
| 10-30 – 12-30 | Education/development session (CM) <ol style="list-style-type: none">1. Introduction to simulation2. The affective domain/professional practice |
| 12-30 – 1 | Debriefing session (Clinical UoS coordinators) |
| 1 – 2 | Lunch and networking |

April 2009

April 2009 Clinical Teacher workshop program

Clinical Teachers Meeting Program

Tuesday 7th April 2009-03-31

| Time | Session | Staff |
|-----------------|--------------------------------------|-------------------------------------|
| 10 to 10-30 ish | Update and changes within the school | SL, MRT & CM |
| 10-30 ish to 12 | Simulation session | CM as leader, other staff as actors |
| 12 to 12-30 ish | Unit of study update | All clinical UoS coordinators |
| 12-30 to 1 | Lunch and networking | All staff |
| 1to 2 | Administrative update | CLO staff |

September 2009

Workshop Content:

| | | |
|----------|---|--------------------------------------|
| 9.00am | Welcome & Introductions | Clive Miller & Stephanie Lockhart |
| 9.15am | Clinical Learning Office Orientation | Ann Caras |
| 10.00 am | Morning Tea | |
| 10.30am | A day in the life of a Clinical Teacher ... | Stephanie Lockhart |
| 11.30am | Overview of HBBN curriculum | Karen Lawrence |
| 12.00md | Lunch | |
| 12.30pm | Documentation – CPAFS & The Bondy Scale | Clive Miller |
| 1.30pm | Overview of 2 nd Semester Units | UoS Co-ords |
| 2.30pm | Evaluations & Close | |

April 2010

**School of Nursing & Midwifery
Victoria University**

**Clinical Teachers Workshop
Wednesday 21 April 2010
Victoria University – St Albans Campus
Bldg 4, Level 1 – Eric Lund Room**

| | | |
|---------|---|---------------------------------------|
| 9.15am | Welcome & Introductions | Clive Miller & Stephanie Lockhart |
| 9.30 am | Clinical Learning Office Orientation | Ann Caras, Andrea Beck & Tania Sambol |
| 10.15am | Morning Tea | |
| 10.30am | Running Small Groups – Trouble shooting! | Stephanie Lockhart |
| 11.30am | Tour of the Clinical Laboratories | Maryanne Craker & Glenda Iskov |
| 12.30pm | Lunch – Room 4C340, level 3, building 4, | With Unit of Study Co-ordinators |
| 1.15pm | The Affective Domain: Presentation, Preparedness and Interaction. | Clive Miller |
| 2.30pm | Evaluations | |
| 3.00pm | Close & Farewells | Clive Miller & Stephanie Lockhart |

Appendix 3

Clinical Performance Assessment Forms (CPAFs)

Appendix 3A – First Clinical Performance Assessment Form collected

SCHOOL OF NURSING & MIDWIFERY
FACULTY OF HEALTH, ENGINEERING & SCIENCE



**VICTORIA
UNIVERSITY**

**A NEW
SCHOOL OF
THOUGHT**

**Clinical Performance Appraisal Form:
Bachelor of Nursing (All courses)
Pre-Registration Course For Overseas Qualified and Re-entry Nurses**

Personal Details Section (Please print)

Student Name: _____

Student ID No: _____

Clinical Venue: _____

Assessor Name: _____

Unit of Study (Code & Name) _____

Dates: From _____ To _____

This tool has been designed using the Australian Nursing & Midwifery Council ([ANMC], 2005) *ANMC National Nursing Competency Standards for the Registered Nurse* (4th ed.) and the work of Bondy (1983; 1984).

Note. Some clinical practicum units may require the student to achieve additional competencies, which will be included in a supplementary sheet.

Assessor Instructions

1. The student is required to complete the Interim Bondy Rating 'Student' section of the Clinical Performance Appraisal Form (CPAF) prior to the assessor completing her/his Interim Bondy Rating of the student.
2. Throughout the first week of the clinical placement, the assessor, in consultation with the student, completes the Interim Bondy Rating 'Assessor' section of the CPAF; documents 'Interim Evidence' to support the rating and, outlines 'Interim Recommendations and Strategies for Development' to guide the student's development.
3. By the end of the final week of the student's clinical placement, the assessor requests the student to complete the Final Bondy Rating 'Student' section of the CPAF.
4. Following this, the assessor, in consultation with the student, completes the:
 - a. Final Bondy Rating 'Assessor' section of the CPAF;
 - b. Final Assessment of the student's performance (Acceptable, Incomplete, or Unacceptable) in the CPAF. If the student has been absent from clinical for one or more days an 'Incomplete' grade is awarded. The Unit Coordinator will then decide if the student will be required to undertake additional clinical practicum.
5. After the assessor has completed the Final Bondy Rating and the Final Assessment of the Student's Performance, the student's signature and comments are obtained.
6. The completed CPAF should be given to the student who is responsible for ensuring that the Form is deposited in the Clinical Learning mail box, located in the School of Nursing and Midwifery. The student should be encouraged to make a copy of the completed CPAF for her/his personal records.

Student Instructions

1. Complete the Personal Details Section of the CPAF and present the Form to the assessor at the commencement of the clinical placement.
2. In the first week of the clinical placement, the student completes the Interim Bondy Rating 'Student' section of the CPAF.
3. In the final week of the clinical placement, the student completes the following parts of the CPAF:
 - a. Final Bondy Rating 'Student' section.
 - b. Student's Self-Evaluation and Comments section
4. To achieve an 'Acceptable' grade the student is required to obtain the rating as set out in Tables 1, 2 & 3. If the student has been absent from clinical for one or more days an 'Incomplete' grade is awarded. The Unit Coordinator will then decide what additional clinical practicum the student will be required to undertake.
5. It is the responsibility of the student to ensure that the completed CPAF is deposited in the Clinical Learning mail box, located in the School of Nursing and Midwifery.

6. The student is encouraged to make a copy of the completed CPAF for her/his personal records. Please note that the Faculty Student Centre will charge a fee if a copy is required from the University's records once the CPAF has been placed in the student's file.

Procedure for students at risk of gaining an 'Unacceptable' grade for their clinical practicum

If learning performance does not reflect progression towards an acceptable level of competence then the student will be required to undergo a Clinical Challenge Learning Contract. Please refer to the Clinical Practicum Assessment Policy, in particular the section dealing with the Clinical Challenge Learning Contract.

Table 1: Bachelor of Nursing (3-year Pre-Registration) minimum competency ratings

| Minimum Competency Rating | | | | | |
|---------------------------|----------|-----------------------|------------------------------|----------------------------------|--------------------------------------|
| Year | Semester | Professional Practice | Critical thinking & analysis | Provision & coordination of care | Collaborative & therapeutic practice |
| 1 | 1 | | | | |
| | 2 | 3 | 3 | 3 | 3 |
| 2 | 1 | 3 | 3 | 3 | 3 |
| | 2 | 4 | 3 | 4 | 3 |
| 3 | 1 | 4 | 4-5 | 5 | 4 |
| | 2 | 5 | 4-5 | 4-5 | 4-5 |

Table 2: Bachelor of Nursing (Division 2 Entry & Graduate Entry) minimum competency ratings

| Minimum Competency Rating | | | | | |
|---------------------------|----------|-----------------------|------------------------------|----------------------------------|--------------------------------------|
| Year | Semester | Professional Practice | Critical thinking & analysis | Provision & coordination of care | Collaborative & therapeutic practice |
| 1 | 1 | 3 | 3 | 3 | 3 |
| | 2 | 4 | 3 | 4 | 3 |
| 2 | 1 | 4 | 4-5 | 5 | 4 |
| | 2 | 5 | 4-5 | 4-5 | 4-5 |

**Table 3: Pre-Registration Course For Overseas Qualified and Re-Entry Nurse
minimum competency ratings**

| Minimum Competency Rating | | | |
|---------------------------|------------------------------|----------------------------------|--------------------------------------|
| Professional Practice | Critical thinking & analysis | Provision & coordination of care | Collaborative & therapeutic practice |
| 5 | 4-5 | 4-5 | 4-5 |

The Bondy Rating Scale

The Bondy Rating Scale is used for assessing clinical performance. The level of performance ranges from Independent (5), Supervised (4), Assisted (3), Marginal (2), to Dependent (1).

INDEPENDENT (5)

- Safe; accurate; achieves the intended purpose each time.
- Always performs in an appropriate manner without supportive cues.
- Proficient; coordinated; confident; occasional expenditure of excess energy; performs in within an expedient time period.

SUPERVISED (4)

- Safe; accurate; achieves the intended purpose each time.
- Always performs in an appropriate manner but occasionally requires supportive cues (e.g. “that’s right”, “keep going”).
- Proficient; coordinated; confident; occasional expenditure of excess energy; performs in within an expedient time period.

ASSISTED (3)

- Safe practice; accurate each time; achieves the intended purpose and performs in an appropriate manner most times.
- Requires frequent verbal and occasional physical directive cues (in an attempt to correct an activity or indicate what is needed next) in addition to supportive ones.
- Skilful in parts of the behaviour; inefficient and un-coordinated; expends excess energy; performs within a delayed time period.

MARGINAL (2)

- Safe practice, but only under supervision; performance not always carried out correctly.
- Requires continuous verbal directive and frequent physical directive cues.
- Unskilled; inefficient, considerable expenditure of excess energy and time.

DEPENDANT (1)

- Unsafe practice; lacks confidence, coordination, and efficiency.
- Unable to satisfactorily demonstrate required level of practice.
- Requires constant direction and excessive supervision.

References

- Bondy, K.N. (1983). Criterion-referenced definitions for rating scales in clinical evaluation. *Journal of Nursing Education*. 22,(9). 376-381
- Bondy, K.N. (1984). Clinical evaluation of students' performance: The effects of criteria on accuracy and reliability. *Research in Nursing and Health*. 7 25-33

Bondy Rating Scale: Independent (5), Supported (4), Assisted (3), Marginal (2), Dependent (1)

| Professional Practice | | Interim rating | | Final rating | |
|------------------------------|--|-----------------------|------------|---------------------|------------|
| | | S* | A** | S* | A** |
| 1. | Practises in accordance with legislation affecting nursing practice and health care. | | | | |
| 2. | Practises within a professional and ethical nursing framework. | | | | |
| 3. | Practises in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups. | | | | |
| 4. | Understands and practises within own scope of practice as a student. | | | | |

| Critical Thinking and Analysis | | Interim rating | | Final rating | |
|---------------------------------------|--|-----------------------|----------|---------------------|----------|
| | | S | A | S | A |
| 5. | Acts to enhance the professional development of self and others. | | | | |
| 6. | Values research in contributing to developments in nursing and improved standards of care. | | | | |

| Provision and Coordination of Care | | Interim rating | | Final rating | |
|---|--|-----------------------|----------|---------------------|----------|
| | | S | A | S | A |
| 7. | Uses a range of assessment techniques to carry out a comprehensive and systematic nursing assessment of individuals and groups in a variety of settings. | | | | |

| | | | | | |
|-----|--|--|--|--|--|
| 8. | Plans nursing care in consultation with individuals/groups, significant others. | | | | |
| 9. | Provides comprehensive, safe and effective, evidence-based nursing care to achieve identified individual/group health outcomes. | | | | |
| 10. | Evaluates progress toward expected individuals/group health outcomes in consultation with individual/group and significant others. | | | | |

| Collaborative and Therapeutic Practice | | Interim rating | | Final rating | |
|---|--|-----------------------|----------|---------------------|----------|
| | | S | A | S | A |
| 11. | Establishes relationships that are goal-directed and recognises professional boundaries. | | | | |
| 12. | Communicates effectively with individuals/groups to facilitate provision of care. | | | | |
| 13. | Uses appropriate strategies to promote an individual's/group's self-esteem, dignity, integrity and comfort. | | | | |
| 14. | Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security. | | | | |

Legend: * = Student, ** = Assessor

Assessor's Signature:

Student's Signature:

Date:

Date:

INTERIM ASSESSMENT OF THE STUDENT'S PERFORMANCE (To be completed by Assessor)

Interim Evidence

- 1.
- 2.
- 3.
- 4.

Additional comments can be made below, if required

Interim Recommendations and Strategies for Development.

- 1.
- 2.
- 3.
- 4.

Additional comments can be made below, if required

| | |
|------------------------------|-------|
| ASSESSOR'S SIGNATURE: | |
| DATE: | |
| STUDENT'S SIGNATURE: | |
| DATE: | |

FINAL ASSESSMENT OF THE STUDENT'S PERFORMANCE (To be completed by Assessor)

Note. The Unit Coordinator has overall responsibility for recommending the final grade that a student is awarded in a unit.

Please provide an overall comment about the student's performance

.....

.....

.....

.....

.....

.....

The student's standard of competence has been judged by the Assessor as:

ACCEPTABLE (Has achieved **BOTH** the competency and attendance requirements for the Unit)

INCOMPLETE (Has achieved the competency requirement **BUT** has **NOT** met the attendance requirement for the Unit)

ABSENCE **Number of days**

DOCUMENTATION PROVIDED FOR ABSENCE **YES**

NO

NUMBER OF DAYS COVERED BY DOCUMENTATION **days**

UNACCEPTABLE (Has **NOT** achieved the required level of competency for the Unit)

STUDENT'S SELF-EVALUATION AND COMMENTS (To be completed by student)

.....

.....

.....

.....

ASSESSOR'S NAME
(PLEASE PRINT) **NBV Registration No.:**

ASSESSOR'S SIGNATURE: **Designation:**

DATE:

STUDENT'S SIGNATURE:

DATE:

School of Nursing and Midwifery, Faculty of Health, Engineering & Science



Victoria University
School of Nursing and Midwifery

Summative (Final) Assessment

CLINICAL PERFORMANCE APPRAISAL TOOL 2008

Unit of Study _____

Student Name _____ Date: _____

Student ID number _____

Student signature _____

Clinical Educator _____

CE signature _____

Clinical Agency _____ Ward/Unit _____

Acknowledgement: This clinical performance appraisal tool has been developed through a University of Melbourne and Victoria University collaborative project

References:

Australian and Nursing Midwifery Council (ANMC) 2002. Code of ethics for nurses in Australia. Available from <http://www.anmc.org.au>

Australian and Nursing Midwifery Council (ANMC) 2003. Code of professional conduct for nurses in Australia. Available from <http://www.anmc.org.au>

Australian and Nursing Midwifery Council (ANMC) 2005. National competencies for the registered nurse: Available from <http://www.anmc.org.au>

Bondy, K.N. 1983. Criterion referenced definitions for rating scales in clinical evaluation. *Journal of Nursing Education* 22(9): 376-382.

Objectives of the appraisal tool:

1. State the expected standards of the student's clinical performance
2. Evaluate the extent to which the student's performance meets the expected clinical standard.
3. Encourage structured student reflection on clinical practice.
4. Facilitate communication between the student, academic and clinical staff in order to provide structured feedback on student's clinical performance.
5. Identify elements of unsatisfactory student performance through a staged appraisal and assessment process consisting of formative performance appraisal and summative assessment.
6. Provide clear documentation of student's clinical development.

The framework of the Clinical performance appraisal tool uses the ANMC National Competency Standards for the Registered Nurse (2005). A summary of the National Competency Standards (ANMC 2005). The appraisal tool is also informed by the Code of Professional Conduct for Nurses in Australia, and the Code of Ethics for Nurses in Australia. All three complete documents are available from www.anmc.org.au and should be utilised in conjunction with the clinical performance appraisal tool.

Competency standards are described within four domains. Examples of performance criteria have been provided for each standard to guide assessment. A rating is to be applied to each competency standard based on the student's achievement of the guiding performance criteria.

The rating applied to each competency standard is based on an adaption of the Bondy Scale (appendix A).

Summative Assessment

The clinical educator will base the assessment on direct observation of student performance, and discussion with the student, clinical staff including unit managers and buddy RN's and other allied health staff, and academic staff. Feedback may also be obtained from the patient and significant others.

The summative assessment is to be completed in the last week of clinical placement. Students who achieve a rating in any shaded portion of the summative assessment tool will be deemed to have failed the clinical component of the subject.

Students are responsible for negotiating an appointment with the clinical educator to complete the summative assessment.

The ability to provide and coordinate care is based on the student's ability to initiate and deliver care within the students scope of practice, and communicate and negotiate the delivery of care outside of their scope of practice.

Grading

A score of 0 to 4 is ascribed to each element of the rating Scale (see Appendix A). A score out of 40 will be determined based on the ratings achieved for each competency standard in the summative appraisal.

Grade 0 – 19 is deemed as unsatisfactory and a **FAIL** in the Clinical Unit of Study

Grade 20 – 40 is deemed as satisfactory and a **PASS** in the Clinical Unit of Study

Domain: Professional Practice

Competency 1: Practices in accordance with legislation affecting nursing practice and health care.

Rating for Competency 1 is based on, but not limited to, assessment of the following performance criteria:

- Maintains confidentiality at all times
- Demonstrates ability to describe and practice within scope of practice consistent with student level.
- Recognises limitations on practice and seeks assistance when required.
- Obtains informed consent prior to conducting health assessments or performing nursing interventions
- Describes and adheres to legal requirements in medication administration consistent with scope of practice.
- Acts in accordance with policies and procedures of the clinical agency
- Documentation is timely, objective and accurate
- Recognises unsafe practice and seeks assistance appropriately
- Performs nursing interventions within a recognised standard of practice.

Please indicate with a check ✓ the relevant score

| | | | | | |
|--------|---|---|---|---|---|
| Rating | 0 | 1 | 2 | 3 | 4 |
|--------|---|---|---|---|---|

Comment to explain ratings, and provide exemplars of practice.

Competency 2: Practices within a professional and ethical nursing framework

Rating for Competency 2 is based on, but not limited to, assessment of the following performance criteria:

- Demonstrates an awareness and acceptance of alternative values, attitudes and behaviours and treats all people with respect.
- Clarifies unclear instructions and/or questions inappropriate interventions with assistance
- Accepts responsibility and accountability for own actions
- Articulates and clarifies their own scope of practice with the health care team.
- Demonstrates strategies of advocating appropriately for patients
- Ensures assessments and interventions are based on current knowledge and evidence of best practice.
- Ensures practice is not compromised by personal health and well being.
- Demonstrates behaviour that encourages the development of confidence and trust.
- Understands the requirements of duties and supervision according to level of practice

| | | | | | |
|---------------|----------|----------|----------|----------|----------|
| Rating | 0 | 1 | 2 | 3 | 4 |
|---------------|----------|----------|----------|----------|----------|

Comment to explain ratings, and provide exemplars of practice.

Domain: CRITICAL THINKING AND ANALYSIS

Competency 3: Practices within an evidence-based framework

Rating for Competency 3 is based on, but not limited to, assessment of the following performance criteria:

- Uses relevant literature and appropriate sources of evidence to inform and improve nursing practice
- Critically analyses assessment findings and planned interventions within an evidence – based framework.
- Nursing interventions are performed following adequate and accurate assessments
- Provides explanations for clinical nursing decisions and judgements reflecting an evidence based framework.

| | | | | | |
|--------|---|---|---|---|---|
| Rating | 0 | 1 | 2 | 3 | 4 |
|--------|---|---|---|---|---|

Comment to explain ratings, and provide exemplars of practice.

Competency 4: Participates in ongoing professional development of self and others

Rating for Competency 4 is based on, but not limited to, assessment of the following performance criteria:

- Identifies own clinical learning objectives and communicates these to the clinical educator and relevant staff.
- Seeks out opportunities to meet objectives
- Actively seeks feedback to improve the quality of nursing care
- Actively participates in group discussions
- Accepts constructive criticism

| | | | | | |
|---------------|----------|----------|----------|----------|----------|
| Rating | 0 | 1 | 2 | 3 | 4 |
|---------------|----------|----------|----------|----------|----------|

Comment to explain ratings, and provide exemplars of practice.

Domain: PROVISION AND COORDINATION OF CARE

Competency 5: Conducts a comprehensive and systematic nursing assessment

Rating for Competency 5 is based on, but not limited to, assessment of the following performance criteria:

- Collects data using a variety of sources and data gathering techniques to inform nursing actions
- Demonstrates a systematic approach to patient assessment using an evidence-based framework
- Discriminates between relevant and irrelevant information
- Conducts and documents comprehensive assessments accurately
- Assessments are conducted with sensitivity to the clients needs
- Identifies changes in health assessment data and takes appropriate action.

| | | | | | |
|--------|---|---|---|---|---|
| Rating | 0 | 1 | 2 | 3 | 4 |
|--------|---|---|---|---|---|

Comment to explain ratings, and provide exemplars of practice.

Competency 6: Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team

Rating for Competency 6 is based on, but not limited to, assessment of the following performance criteria:

- Nursing plan and interventions are based on assessment data
- Priorities for care are based on individual and group assessment
- Outcomes of interventions and nursing care plan are identified
- Interventions and outcomes are based on theoretical knowledge
- Plans of care are developed in collaboration with members of the health care team
- Plans of care are documented clearly
- Plan is changed according to ongoing assessment and evaluation of individuals/groups.

| | | | | | |
|---------------|----------|----------|----------|----------|----------|
| Rating | 0 | 1 | 2 | 3 | 4 |
|---------------|----------|----------|----------|----------|----------|

Comment to explain ratings, and provide exemplars of practice.

Competency 7: Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health outcomes

Rating for Competency 7 is based on, but not limited to, assessment of the following performance criteria:

- Adheres to a documented plan of care
- Maintains a safe environment for patient, other staff and self
- Demonstrates dexterity in performing motor skills and nursing interventions
- Performs actions required for nursing interventions logically and appropriately as the situation demands
- Uses standard precautions consistently and additional precautions when required.
- Demonstrates an understanding of and adherence to the principles of aseptic technique.
- Adjusts interventions and care plans as required according to patient responses
- Seeks assistance appropriately when requirements of care provision are outside of scope of practice.
- Communication is maintained during provision of interventions/care
- Resources required for the provision of care are used effectively and responsibly.

| | | | | | |
|---------------|----------|----------|----------|----------|----------|
| Rating | 0 | 1 | 2 | 3 | 4 |
|---------------|----------|----------|----------|----------|----------|

Comment to explain ratings, and provide exemplars of practice.

Competency 8: Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and interdisciplinary health care team.

Rating for Competency 8 is based on, but not limited to, assessment of the following performance criteria:

- Demonstrates inclusion of consideration of continuity of care into planning
- Demonstrates inclusion of consideration of discharge planning
- Evaluates nursing care in terms of patient response
- Considers desired outcomes in evaluation
- Revises the plan of care based on patients response and progress towards identified outcomes
- Communicates information related to patient progress to members of the health care team

| | | | | | |
|---------------|----------|----------|----------|----------|----------|
| Rating | 0 | 1 | 2 | 3 | 4 |
|---------------|----------|----------|----------|----------|----------|

Comment to explain ratings, and provide exemplars of practice.

Domain: COLLABORATIVE AND THERAPEUTIC PRACTICE

Competency 9: Establishes, maintains and appropriately concludes therapeutic relationships

Rating for Competency 9 is based on, but not limited to, assessment of the following performance criteria:

- Identifies barriers to communication and uses appropriate strategies to communicate effectively with patients, family, significant others and other members of the health care team.
- Listens carefully to the patient and members of the allied health care team and seeks clarification when necessary.
- Develops relationships with the patient and family that have a therapeutic goal and recognise professional boundaries.
- Is able to maintain communication through situations that may be difficult or stressful.
- Avoids the use of platitudes and false assurances as a means of communication
- Seeks guidance from clinical educator or clinical staff if unsure how to respond to issues.

| | | | | | |
|---------------|----------|----------|----------|----------|----------|
| Rating | 0 | 1 | 2 | 3 | 4 |
|---------------|----------|----------|----------|----------|----------|

Comment to explain ratings, and provide exemplars of practice.

Competency 10: Collaborates with the interdisciplinary health care team to provide comprehensive nursing care

Rating for Competency 10 is based on, but not limited to, assessment of the following performance criteria:

- Respects experience and knowledge of colleagues within specific contexts
- Liaises with members of the health care team in order to coordinate an effective plan of care
- Uses appropriate communication strategies to relay information accurately to establish and maintain continuity of care.
- Collaborates with other health care professionals to determine the plan of care and evaluate achievement of outcomes.
- Demonstrates an ability to participate as part of a team.

| | | | | | |
|---------------|----------|----------|----------|----------|----------|
| Rating | 0 | 1 | 2 | 3 | 4 |
|---------------|----------|----------|----------|----------|----------|

Comment to explain ratings, and provide exemplars of practice.

Summative Feedback:

Assessor's comments: _____ **Date:** _____

Student's comments: _____ **Date:** _____

APPENDIX A GUIDELINES FOR STUDENT CLINICAL PRACTICE ASSESSMENT:

| Rating Score | ASSISTANCE REQUIRED | QUALITY OF PERFORMANCE | PROFESSIONAL STANDARD |
|---------------------|--|--|---|
| Rating 4 | <ul style="list-style-type: none"> Without supporting cues | <ul style="list-style-type: none"> Proficient, coordinated, confident. Occasional expenditure of excess energy. Performs within an excellent time period. | <ul style="list-style-type: none"> Safe and Accurate Consistently achieves the intended purpose Consistently performs in an appropriate manner |
| Rating 3 | <ul style="list-style-type: none"> Occasional supportive cues | <ul style="list-style-type: none"> Efficient, coordinated confident Occasional expenditure of excess energy Performs within a reasonable time period. | <ul style="list-style-type: none"> Safe and Accurate Consistently achieves the intended purpose Consistently performs in an appropriate manner. |
| Rating 2 | <ul style="list-style-type: none"> Frequent verbal and occasional physical directive cues in addition to supportive cues. | <ul style="list-style-type: none"> Skilful in parts of behaviour Inefficient and uncoordinated Expend excess energy Performs within a delayed time period. | <ul style="list-style-type: none"> Safe and Accurate Achieves the intended purpose most of the time. Performs in an appropriate manner most of the time |
| Rating 1* | <ul style="list-style-type: none"> Continuous verbal and frequent physical cues. | <ul style="list-style-type: none"> Unskilled, Inefficient Considerable expenditure of energy. Performs within a prolonged time period. | <ul style="list-style-type: none"> Safe if supervised, performs alone at risk. Not always accurate Occasionally achieves the intended purpose Occasionally performs in an appropriate manner. |
| Rating 0* | <ul style="list-style-type: none"> Requires procedure to be completed by Clinical Educator/Clinical Preceptor. | <ul style="list-style-type: none"> Unable to demonstrate procedure or behaviour Lacks confidence, coordination | <ul style="list-style-type: none"> Performs at a dependant level requiring constant supervision and direction. Unsafe Unable to demonstrate intended behaviour |

Adapted from Bondy (1983)

*** Students who are rated at level 0 or 1 at the summative assessment may be deemed by the subject coordinator to have failed the subject.**

Appendix 3C – Third and fourth Clinical Performance Assessment Form

collected



**Victoria University
School of Nursing and Midwifery**

Summative (Final) Assessment

**CLINICAL PERFORMANCE APPRAISAL TOOL
2008**

Unit of Study

Student Name _____

Student ID number _____

Student signature _____

Clinical Educator _____

CE signature _____

Clinical Agency _____

Ward/Unit

Date To _____

From

| |
|--|
| |
|--|

Acknowledgement: This clinical performance appraisal tool has been developed through a University of Melbourne and Victoria University collaborative project

Domain: Professional Practice

Competency 1: Practices in accordance with legislation affecting nursing practice and health care.

Rating for Competency 1 is based on, but not limited to, assessment of the following performance criteria:

- Maintains confidentiality at all times
- Demonstrates ability to describe and practice within scope of practice consistent with student level.
- Recognises limitations on practice and seeks assistance when required.
- Obtains informed consent prior to conducting health assessments or performing nursing interventions
- Describes and adheres to legal requirements in medication administration consistent with scope of practice
- Acts in accordance with policies and procedures of the clinical agency
- Documentation is timely, objective and accurate
- Recognises unsafe practice and seeks assistance appropriately
- Performs nursing interventions within a recognised standard of practice.

Rating

0

1

2

3

4

Comment to explain ratings, and provide exemplars of practice.

Competency 2: Practices within a professional and ethical nursing framework

Rating for Competency 2 is based on, but not limited to, assessment of the following performance criteria:

- Demonstrates an awareness and acceptance of alternative values, attitudes and behaviours and treats all people with respect.
- Clarifies unclear instructions and/or questions inappropriate interventions with assistance
- Accepts responsibility and accountability for own actions
- Demonstrates behaviour that encourages the development of confidence and trust.
- Understands the requirements of duties and supervision according to level of practice
- Articulates and clarifies their own scope of practice with the health care team.
- Demonstrates strategies of advocating appropriately for patients
- Ensures assessments and interventions are based on current knowledge and evidence of best practice.
- Ensures practice is not compromised by personal health and well being.

Rating

0

1

2

3

4

Comment to explain ratings, and provide exemplars of practice.

Domain: CRITICAL THINKING AND ANALYSIS

Competency 3: Practices within an evidence-based framework

Rating for Competency 3 is based on, but not limited to, assessment of the following performance criteria:

- Uses relevant literature and appropriate sources of evidence to inform and improve nursing practice
- Critically analyses assessment findings and planned interventions within an evidence – based framework.
- Nursing interventions are performed following adequate and accurate assessments
- Provides explanations for clinical nursing decisions and judgements reflecting an evidence based framework.

Rating 0 1 2 3 4

Comment to explain ratings, and provide exemplars of practice.

Competency 4: Participates in ongoing professional development of self and others

Rating for Competency 4 is based on, but not limited to, assessment of the following performance criteria:

- Identifies own clinical learning objectives and communicates these to the clinical educator and relevant staff.
- Seeks out opportunities to meet objectives
- Actively seeks feedback to improve the quality of nursing care
- Actively participates in group discussions
- Accepts constructive criticism

Rating 0 1 2 3 4

Comment to explain ratings, and provide exemplars of practice.

Domain: PROVISION AND COORDINATION OF CARE

Competency 5: Conducts a comprehensive and systematic nursing assessment

Rating for Competency 5 is based on, but not limited to, assessment of the following performance criteria:

- Collects data using a variety of sources and data gathering techniques to inform nursing actions
- Demonstrates a systematic approach to patient assessment using an evidence-based framework
- Discriminates between relevant and irrelevant information
- Conducts and documents comprehensive assessments accurately
- Assessments are conducted with sensitivity to the clients needs
- Identifies changes in health assessment data and takes appropriate action.

Rating **0** **1** **2** **3** **4**

Comment to explain ratings, and provide exemplars of practice.

Competency 6: Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team

Rating for Competency 6 is based on, but not limited to, assessment of the following performance criteria:

- Nursing plan and interventions are based on assessment data
- Priorities for care are based on individual and group assessment
- Outcomes of interventions and nursing care plan are identified
- Interventions and outcomes are based on theoretical knowledge
- Plans of care are developed in collaboration with members of the health care team
- Plans of care are documented clearly
- Plan is changed according to ongoing assessment and evaluation of individuals/groups.

Rating **0** **1** **2** **3** **4**

Comment to explain ratings, and provide exemplars of practice.

Competency 7: Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health outcomes

Rating for Competency 7 is based on, but not limited to, assessment of the following performance criteria:

- Adheres to a documented plan of care
- Maintains a safe environment for patient, other staff and self
- Demonstrates dexterity in performing motor skills and nursing interventions
- Performs actions required for nursing interventions logically and appropriately as the situation demands
- Uses standard precautions consistently and additional precautions when required.
- Demonstrates an understanding of and adherence to the principles of aseptic technique.
- Adjusts interventions and care plans as required according to patient responses
- Seeks assistance appropriately when requirements of care provision are outside of scope of practice.
- Communication is maintained during provision of interventions/care
- Resources required for the provision of care are used effectively and responsibly.

Rating **0** **1** **2** **3** **4**
Comment to explain ratings, and provide exemplars of practice.

Competency 8: Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and interdisciplinary health care team.

Rating for Competency 8 is based on, but not limited to, assessment of the following performance criteria:

- Demonstrates inclusion of consideration of continuity of care into planning
- Demonstrates inclusion of consideration of discharge planning
- Evaluates nursing care in terms of patient response
- Considers desired outcomes in evaluation
- Revises the plan of care based on patients response and progress towards identified outcomes
- Communicates information related to patient progress to members of the health care team

Rating **0** **1** **2** **3** **4**
Comment to explain ratings, and provide exemplars of practice.

Domain: COLLABORATIVE AND THERAPEUTIC PRACTICE

Competency 9: Establishes, maintains and appropriately concludes therapeutic relationships

Rating for Competency 9 is based on, but not limited to, assessment of the following performance criteria:

- Identifies barriers to communication and uses appropriate strategies to communicate effectively with patients, family, significant others and other members of the health care team.
- Listens carefully to the patient and members of the allied health care team and seeks clarification when necessary.
- Develops relationships with the patient and family that have a therapeutic goal and recognise professional boundaries.
- Is able to maintain communication through situations that may be difficult or stressful.
- Avoids the use of platitudes and false assurances as a means of communication
- Seeks guidance from clinical educator or clinical staff if unsure how to respond to issues.

Rating 0 1 2 3 4

Comment to explain ratings, and provide exemplars of practice.

Competency 10: Collaborates with the interdisciplinary health care team to provide comprehensive nursing care

Rating for Competency 10 is based on, but not limited to, assessment of the following performance criteria:

- Respects experience and knowledge of colleagues within specific contexts
- Liaises with members of the health care team in order to coordinate an effective plan of care
- Uses appropriate communication strategies to relay information accurately to establish and maintain continuity of care.
- Collaborates with other health care professionals to determine the plan of care and evaluate achievement of outcomes.
- Demonstrates an ability to participate as part of a team.

Rating 0 1 2 3 4

Comment to explain ratings, and provide exemplars of practice.

Summative Feedback:

Assessor's comments: **Date:** _____

Student's comments: **Date:** _____

APPENDIX A GUIDELINES FOR STUDENT CLINICAL PRACTICE ASSESSMENT:

| Rating Score | ASSISTANCE REQUIRED | QUALITY OF PERFORMANCE | PROFESSIONAL STANDARD |
|---------------------|--|--|---|
| Rating 4 | <ul style="list-style-type: none"> Without supporting cues | <ul style="list-style-type: none"> Proficient, coordinated, confident. Occasional expenditure of excess energy. Performs within an excellent time period. | <ul style="list-style-type: none"> Safe and Accurate Consistently achieves the intended purpose Consistently performs in an appropriate manner |
| Rating 3 | <ul style="list-style-type: none"> Occasional supportive cues | <ul style="list-style-type: none"> Efficient, coordinated confident Occasional expenditure of excess energy Performs within a reasonable time period. | <ul style="list-style-type: none"> Safe and Accurate Consistently achieves the intended purpose Consistently performs in an appropriate manner. |
| Rating 2 | <ul style="list-style-type: none"> Frequent verbal and occasional physical directive cues in addition to supportive cues. | <ul style="list-style-type: none"> Skilful in parts of behaviour Inefficient and uncoordinated Expend excess energy Performs within a delayed time period. | <ul style="list-style-type: none"> Safe and Accurate Achieves the intended purpose most of the time. Performs in an appropriate manner most of the time |
| Rating 1* | <ul style="list-style-type: none"> Continuous verbal and frequent physical cues. | <ul style="list-style-type: none"> Unskilled, Inefficient Considerable expenditure of energy. Performs within a prolonged time period. | <ul style="list-style-type: none"> Safe if supervised, performs alone at risk. Not always accurate Occasionally achieves the intended purpose Occasionally performs in an appropriate manner. |
| Rating 0* | <ul style="list-style-type: none"> Requires procedure to be completed by Clinical Educator/Clinical Preceptor. | <ul style="list-style-type: none"> Unable to demonstrate procedure or behaviour Lacks confidence, coordination | <ul style="list-style-type: none"> Performs at a dependant level requiring constant supervision and direction. Unsafe Unable to demonstrate intended behaviour |

Adapted from Bondy (1983)

*** Students who are rated at level 0 or 1 at the summative assessment may be deemed by the subject coordinator to have failed the subject.**

Appendix 4

Consent forms and Information sheets

These are presented in the following order:

1. Consent form for Clinical Teachers (Individual interview)
2. Consent form for Nursing Students (Group focus group)
3. Information for participants – Clinical teachers
4. Information for participants – Nursing students

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS (Clinical teachers):

We would like to invite you to be a part of a study into the preparation of clinical teachers and the effect this has on the learning of students as described on the Information to Participants Involved in Research: Clinical teachers provided.

CERTIFICATION BY SUBJECT

I

of

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study:

Clinical Teachers preparation: what is the effect on students learning?

being conducted at Victoria University by:

Dr Colleen Vale (Principal researcher) and

Mr Clive Miller (Student)

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Clive Miller

and that I freely consent to participation involving the use on me of these procedures:

- **Two individual interviews that are audio-recorded and**
- **Two focus group discussions that are audio-recorded**

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Witness other than the researcher:

Date:

Any queries about your participation in this project may be directed to the researcher Dr. Colleen Vale (Ph. 99194893). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781

[*please note: Where the participant/s are aged under 18, separate parental consent is required; where the participant/s are unable to answer for themselves due to mental illness or disability, parental or guardian consent may be required.]

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS (Nursing students):

We would like to invite you to be a part of a study into the preparation of clinical teachers and the effect this has on the learning of students as described on the Information to Participants Involved in Research: Nursing students provided.

CERTIFICATION BY SUBJECT

I

of

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study:

Clinical Teachers preparation: what is the effect on students learning?

being conducted at Victoria University by:

Dr Colleen Vale (Principal researcher) and

Mr Clive Miller (Student)

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Clive Miller

and that I freely consent to participation involving the use on me of these procedures:

- **A Focus Group discussion that is audio-recorded**

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Witness other than the researcher:

Date:

Any queries about your participation in this project may be directed to the researcher Dr. Colleen Vale (Ph. 99194893). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781

[*please note: Where the participant/s are aged under 18, separate parental consent is required; where the participant/s are unable to answer for themselves due to mental illness or disability, parental or guardian consent may be required.]

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH Clinical teachers

You are invited to participate

You are invited to participate in a research project entitled

Clinical Teachers preparation: What is the effect on student's learning?

Project explanation

The aim of the study is to investigate the effect of a program of preparation and support for clinical teachers on students' learning. In particular it will identify whether a clinical teacher development program will produce effective results in both supporting the clinical teacher and for them to support the students they supervise. That is, effective results will be considered as an improvement in the quality of student supervision and an improvement in students' learning.

What will I have to do?

You are being asked to participate in a maximum of two individual interviews and two focus groups which will be spread over a period of 18 months to 2 years. Both the interviews and focus groups are not anticipated to last for more than one hour and may be briefer. You do not have to commit to all four sessions at the commencement as formal consent will be obtained for each session.

The questions asked in both the interviews and focus groups will be around your role of a clinical teacher, how you see this role, how you practice in this role and what helps or hinders you in undertaking this role.

You are also being asked to complete a written questionnaire that asks you to record an incident concerning the supervision of a student in clinical practice. Your written response will be discussed in an interview or focus group.

What will I gain from participating?

You will benefit from participating in this research since the information you provide will be used to support you and other clinical teachers and to develop your skills and knowledge in supervising nursing student in clinical settings. In turn this will benefit future students with better support and learning while on clinical practicum.

Depending on the time of day the focus groups are held appropriate refreshments will be available to participants.

How will the information I give be used?

The information gathered during these sessions will be used in two ways:

1. to inform the development of clinical teacher's study days and debriefing sessions
2. as data for the thesis produced from this work

What are the potential risks of participating in this project?

There is minimal risk to your participation. There may be a perceived risk in that you may feel that participation may affect your employment with the School of Nursing and Midwifery. If the researcher is involved in any decisions regarding your employment you will not be asked to participate in that semester's research activity. You will also not be asked to participate where the researcher has been involved in the coordination or facilitation of the clinical practicum/s you are currently involved with.

To maintain your confidentiality no names will be used in any reports or the thesis produced from these interviews. All participants will be given a simple code to identify them for the purpose of linking data if needed. This will be a letter number code, e.g. CT1 FG1.

How will this project be conducted?

The research project uses a method called Design Research. This method of research is useful when designing an innovation in teaching and learning. It involves making changes to elements of the program over a series of trials to improve and achieve the educational outcomes sought. In the case of this research it is the development of a program for clinical teachers employed by a School of Nursing and Midwifery.

To be able to assess the effect of the content on the outcome it is necessary to collect data from a variety of relevant sources to assess the effect on the outcomes. These sources include your participation, focus groups with students and the use of information and data collected by the School of Nursing and Midwifery. The process used is a circular one where data collected after one session is used to help inform the content of the next session.

Who is conducting the study?

This study is being conducted by Clive Miller, lecturer, School of Nursing and Midwifery as the Student Researcher (Ph 9919 2387 or E-mail clive.miller@vu.edu.au) and Dr Colleen Vale of the School of Education, Victoria University, who is the principal researcher (Ph 9919 4893 or E-mail colleen.vale@vu.edu.au).

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 Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH Nursing students

You are invited to participate

You are invited to participate in a research project entitled

Clinical Teachers preparation: What is the effect on student's learning?

Project explanation

The aim of the study is to investigate the effect of a program of preparation and support for clinical teachers on students' learning. In particular it will identify whether a clinical teacher development program will produce effective results in both supporting the clinical teacher and for them to support the students they supervise. That is, effective results will be considered as an improvement in the quality of student supervision and an improvement in students' learning.

What will I have to do?

You will be asked to participate in one focus group with a small number of other students. This will be recorded by the researcher and transcribed for his later use. It is anticipated that the focus group will last for approximately one hour.

You will be given a transcript of the recording to further comment on if you wish.

What will I gain from participating?

There will be little if any direct benefit to you in participation in this focus group. The information will be used to improve the development of clinical teachers therefore in the future this will benefit future students with better support and learning while on clinical practicum's.

Depending on the time of day the focus groups are held appropriate refreshments will be available to participants.

How will the information I give be used?

The information gathered during these sessions will be used in two ways:

1. to inform the development of clinical teacher's study days and debriefing sessions
2. as data for the thesis produced from this work

What are the potential risks of participating in this project?

There is minimal risk to your participation. You may be concerned that your grading for a unit may be affected by your participation, but this will not occur. The focus group will be held after the clinical practicum has been held and therefore grades already entered. You will also not be asked to participate where the researcher has been involved in the coordination or facilitation of your clinical practicum.

To maintain your confidentiality no names will be used in any reports or the thesis produced from these interviews. All participants will be given a simple code to identify them for the purpose of linking data if needed. This will be a letter number code, e.g. S1 FG1.

How will this project be conducted?

The research project uses a method called Design Research. This method of research is useful when designing an innovation in teaching and learning. It involves making changes to elements of the program over a series of trials to improve and achieve the educational outcomes sought. In the case of this research it is the development of a program for clinical teachers employed by a School of Nursing and Midwifery.

To be able to assess the effect of the content on the outcome it is necessary to collect data from a variety of relevant sources to assess the effect on the outcomes. These sources include your participation, interviews and focus groups with clinical teachers and the use of information and data collected by the School of Nursing and Midwifery. The process used is a circular one where data collected after one session is used to help inform the content of the next session.

Who is conducting the study?

This study is being conducted by Clive Miller, lecturer, School of Nursing and Midwifery as the Student Researcher (Ph 9919 2387 or E-mail clive.miller@vu.edu.au) and Dr Colleen Vale of the School of Education, Victoria University who is the principal researcher (Ph 9919 4893 or E-mail colleen.vale@vu.edu.au).

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 Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

Appendix 5

Australian Nursing and Midwifery Council Competency Standards



National Competency Standards for the Registered Nurse

INTRODUCTION

DESCRIPTION OF REGISTERED NURSE

DOMAINS

NATIONAL COMPETENCY STANDARDS

GLOSSARY OF TERMS

Introduction

The Australian Nursing and Midwifery Council Incorporated (ANMC) is a peak national nursing and midwifery organisation established in 1992 with the purpose of developing a national approach to nursing and midwifery regulation. The ANMC works in conjunction with the state and territory nursing and midwifery regulatory authorities (NMRAs) to produce national standards which are an integral component of the regulatory framework to assist nurses and midwives to deliver safe and competent care.

The standards include the national competency standards for registered nurses which were first adopted by the ANMC in the early 1990s. These have been reviewed and revised regularly since then. Other standards developed by the ANMC for implementation by the NMRAs include the competency standards for enrolled nurses, midwives and nurse practitioners, codes of professional conduct and ethics, and a range of position statements and guidelines. The full list of standards, position papers and guidelines produced by the ANMC can be viewed on the website.

In 2004/2005 the ANMC undertook a review of the national competency standards for the registered nurse to ensure that they remain contemporary and congruent with the legislative requirements of the NMRAs. This review, which was undertaken by a team of expert nursing consultants, included extensive consultation with nurses around Australia. The resulting standards, whilst different in some areas from the previous competency standards, remain broad and principle based so that they are sufficiently dynamic for practicing nurses and the NMRAs to use as a benchmark to assess competence to practice in a range of settings.

What are the standards used for?

The national competency standards for the registered nurse are the core competency standards by which your performance is assessed to obtain and retain your license to practice as a registered nurse in Australia.

As a registered nurse, these core competency standards provide you with the framework for assessing your competence, and are used by your state/territory NMRA to assess competence as part of the annual renewal of license process, to

assess nurses educated overseas seeking to work in Australia, and to assess nurses returning to work after breaks in service. They are also used to assess nurses involved in professional conduct matters. The NMRAs may also apply the competency standards in order to communicate to consumers the standards that they can expect from nurses.

Universities also use the standards when developing nursing curricula, and to assess student and new graduate performance.

These are YOUR standards – developed using the best possible evidence, and using information and feedback provided by nurses in a variety of settings. Included also are the principles of assessment which will assist you in understanding how these standards may be used to assess performance. We believe you will find them easy to understand, and user friendly.

ANMC would like to thank nurses throughout Australia for their willing input to the development of these standards.

Description of the registered nurse on entry to practice

The registered nurse demonstrates competence in the provision of nursing care as specified by the registering authority's licence to practice, educational preparation, relevant legislation, standards and codes, and context of care. The registered nurse practices independently and interdependently assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers. Delegation takes into consideration the education and training of enrolled nurses and health care workers and the context of care.

The registered nurse provides evidence-based nursing care to people of all ages and cultural groups, including individuals, families and communities. The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individual/s with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life.

The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individual/s and the multidisciplinary health care team so as to achieve goals and health outcomes. The registered nurse recognises



that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual's responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately. The registered nurse provides care in a range of settings that may include acute, community, residential and extended care settings, homes, educational institutions or other work settings and modifies practice according to the model/s of care delivery.

The registered nurse takes a leadership role in the coordination of nursing and health care within and across different care contexts to facilitate optimal health outcomes. This includes appropriate referral to, and consultation with, other relevant health professionals, service providers, and community and support services.

The registered nurse contributes to quality health care through lifelong learning and professional development of herself/himself and others, research data generation, clinical supervision and development of policy and clinical practice guidelines. The registered nurse develops their professional practice in accordance with the health needs of the population/society and changing patterns of disease and illness.

Domains

The competencies which make up the ANMC National Competency Standards for the Registered Nurses are organised into domains.

Professional Practice

This relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.

Critical Thinking and Analysis

This relates to self – appraisal, professional development, and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark.

Provision and Coordination of Care

This domain relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals /groups, planning, implementation and evaluation of care.

Collaborative and Therapeutic Practice

This relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to the nurse understanding their contribution to the interdisciplinary health care team.

National Competency Standards for the Registered Nurse

PROFESSIONAL PRACTICE

Relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.

1. Practises in accordance with legislation affecting nursing practice and health care

1.1 Complies with relevant legislation and common law

- identifies legislation governing nursing practice
- describes nursing practice within the requirements of common law
- describes and adheres to legal requirements for medication/s
- identifies legal implications of nursing interventions
- actions demonstrate awareness of legal implications of nursing practice
- identifies and explains effects of legislation on the care of individuals/groups
- identifies and explains effects of legislation in the area of health
- identifies unprofessional practice as it relates to confidentiality and privacy legislation

1.2 Fulfils the duty of care

- performs nursing interventions in accordance with recognised standards of practice
- clarifies responsibility for aspects of care with other members of the health team
- recognises the responsibility to prevent harm
- performs nursing interventions following comprehensive and accurate assessments

1.3 Recognises and responds appropriately to unsafe or unprofessional practice

- identifies interventions which prevent care being compromised and/or law contravened
- identifies appropriate action to be taken in specified circumstances
- identifies and explains alternative strategies for intervention and their likely outcomes
- identifies behaviour that is detrimental to achieving optimal care
- follows up incidents of unsafe practice to prevent re-occurrence

2. Practises within a professional and ethical nursing framework

2.1 Practices in accordance with the nursing profession's codes of ethics and conduct

- accepts individuals/groups regardless of race, culture, religion, age, gender, sexual preference, physical or mental state
- ensures that personal values and attitudes are not imposed on others



- conducts assessments that are sensitive to the needs of individuals/groups
 - recognises and accepts the rights of others
 - maintains an effective process of care when confronted by differing values, beliefs and biases
 - seeks assistance to resolve situations involving moral conflict
 - identifies and attempts to overcome factors which may constrain ethical decisions in consultation with the health care team
- 2.2 Integrates organisational policies and guidelines with professional standards**
- maintains current knowledge of and incorporates relevant professional standards in to practice
 - maintains current knowledge of and incorporates organisational policies and guidelines in to practice
 - reviews and provides feedback on the relevance of organisational policies and professional standards procedures to practice
 - demonstrates awareness and understanding of developments in nursing that have an impact on the individual's capacity to practice nursing
 - considers individual health and wellbeing in relation to being fit for practice
- 2.3 Practises in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups**
- demonstrates respect for individual/group common and legal rights in relation to health care
 - identifies and adheres to strategies to promote and protect individual/group rights
 - considers individual/group preferences when providing care
 - clarifies individual/group requests to change and/or refuse care with relevant members of the health care team
 - advocates for individuals/groups when rights are overlooked and/or compromised
 - accepts individuals/groups to whom care is provided regardless of race, culture, religion, age, gender, sexual preference, physical or mental state
 - ensures that personal values and attitudes are not imposed on others
 - undertakes assessments which are sensitive to the needs of individuals/groups
 - recognises and accepts the rights of others
 - maintains an effective process of care when confronted by differing values, beliefs and biases
 - provides appropriate information within the nurse's scope of practice to individuals/groups
 - consults relevant members of the health care team when required
 - questions and/or clarifies orders and decisions that are unclear, not understood or questionable
 - questions and/or clarifies interventions that appear inappropriate with relevant members of the health care team
- 2.4 Advocates for individuals/groups and their rights for nursing and health care within organisational and management structures**
- identifies when resources are insufficient to meet care needs of individuals/groups
 - communicates skill mix requirements to meet care needs of individuals/groups to management
- protects the rights of individuals and groups and facilitates informed decisions
 - identifies and explains policies/practices which infringe on the rights of individuals or groups
 - clarifies policies, procedures and guidelines when rights of individuals or groups are compromised
 - recommends changes to policies, procedures and guidelines when rights are compromised
- 2.5 Understands and practises within own scope of practice**
- seeks clarification when questions, directions and decisions are unclear or not understood
 - undertakes decisions about care that are within scope of competence without consulting senior staff
 - raises concerns about inappropriate delegation with the appropriate registered nurse
 - demonstrates accountability and responsibility for own actions within nursing practice
 - assesses consequences of various outcomes of decision making
 - consults relevant members of the health care team when required
 - questions and/or clarifies interventions which appear inappropriate with relevant members of the health care team
- 2.6 Integrates nursing and health care knowledge, skills and attitudes to provide safe and effective nursing care**
- maintains a current knowledge base
 - considers ethical responsibilities in all aspects of practice
 - ensures privacy and confidentiality when providing care
 - questions and/or clarifies interventions which appear inappropriate with relevant members of the health care team
- 2.7 Recognises the differences in accountability and responsibility between Registered Nurses, Enrolled Nurses and unlicensed care workers**
- understands requirements of statutory and professionally regulated practice
 - understands requirements for delegation and supervision of practice
 - raises concerns about inappropriate delegation with relevant organisational or regulatory personnel



CRITICAL THINKING AND ANALYSIS

Relates to self-appraisal, professional development and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark.

3 Practises within an evidence-based framework**3.1 Identifies the relevance of research to improving individual/group health outcomes**

- identifies problems/issues in nursing practice which may be investigated through research
- considers potential for improvement in reviewing the outcomes of nursing activities and individual/group care
- discusses implications of research with colleagues
- participates in research
- demonstrates awareness of current research in own field of practice

3.2 Uses best available evidence, nursing expertise and respect for the values and beliefs of individuals/groups in the provision of nursing care

- uses relevant literature and research findings to improve current practice
- participates in review of policies, procedures and guidelines based on relevant research
- identifies and disseminates relevant changes in practice or new information to colleagues
- recognises that judgements and decisions are aspects of nursing care
- recognises that nursing expertise varies with education, experience and context of practice

3.3 Demonstrates analytical skills in accessing and evaluating health information and research evidence

- demonstrates understanding of the registered nurse role in contributing to nursing research
- undertakes critical analysis of research findings in considering their application to practice
- maintains accurate documentation of information which could be used in nursing research
- clarifies when resources are not understood or their application is questionable

3.4 Supports and contributes to nursing and health care research

- participates in research
- identifies problems suitable for research

3.5 Participates in quality improvement activities

- recognises that quality improvement involves ongoing consideration, use and review of practice in relation to practice outcomes, standards and guidelines and new developments
- seeks feedback from a wide range of sources to improve the quality of nursing care
- participates in case review activities
- participates in clinical audits

4. Participates in ongoing professional development of self and others**4.1 Uses best available evidence, standards and guidelines to evaluate nursing performance**

- undertakes regular self-evaluation of own nursing practice
- seeks and considers feedback from colleagues about, and critically reflects on, own nursing practice
- participates actively in performance review processes

4.2 Participates in professional development to enhance nursing practice

- reflects on own practice to identify professional development needs
- seeks additional knowledge and/or information when presented with unfamiliar situations
- seeks support from colleagues in identifying learning needs
- participates actively in ongoing professional development
- maintains records of involvement in professional development which includes both formal and informal activities

4.3 Contributes to the professional development of others

- demonstrates an increasing responsibility to share knowledge with colleagues
- supports health care students to meet their learning objectives in cooperation with other members of the health care team
- facilitates mutual sharing of knowledge and experience with colleagues relating to individual/group/unit problems
- contributes to orientation and ongoing education programs
- acts as a role model to other members of the health care team
- participates where possible in preceptorship, coaching and mentoring to assist and develop colleagues
- participates where appropriate in teaching others including students of nursing and other health disciplines, and inexperienced nurses
- contributes to formal and informal professional development

4.4 Uses appropriate strategies to manage own responses to the professional work environment

- identifies and uses support networks
- shares experiences related to professional issues mutually with colleagues
- uses reflective practice to identify personal needs and seek appropriate support



PROVISION AND COORDINATION OF CARE

Relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals/groups, planning, implementation and evaluation of care.

5. Conducts a comprehensive and systematic nursing assessment**5.1 Uses a relevant evidence-based assessment framework to collect data about the physical socio-cultural and mental health of the individual/group**

- approaches and organises assessment in a structured way
- uses all available evidence sources, including individuals/groups/significant others, health care team, records, reports, and own knowledge and experience
- collects data that relates to physiological, psychological, spiritual, socio-economic and cultural variables on an ongoing basis
- understands the role of research-based, and other forms of evidence
- confirms data with the individual/group and members of the health care team
- uses appropriate assessment tools and strategies to assist the collection of data
- frames questions in ways that indicate the use of a theoretical framework/structured approach
- ensures practice is sensitive and supportive to cultural issues

5.2 Uses a range of assessment techniques to collect relevant and accurate data

- uses a range of data gathering techniques, including observation, interview, physical examination and measurement in obtaining a nursing history and assessment
- collaboratively identifies actual and potential health problems through accurate interpretation of data
- accurately uses health care technologies in accordance with manufacturer's specification and organisational policy
- identifies deviations from normal, or improvements in the individual's/group's, health status
- identifies and incorporates the needs and preferences of individuals/group into a plan of care

5.3 Analyses and interprets assessment data accurately

- recognises that clinical judgements involve consideration of conflicting information and evidence
- identifies types and sources of supplementary information for nursing assessment
- describes the role of supplementary information in nursing assessment
- demonstrates knowledge of quantitative and qualitative data to assess individual/group needs

6. Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team**6.1 Determines agreed priorities for resolving health needs of individuals/groups**

- incorporates relevant assessment data in developing a plan for care
- determines priorities for care, based on nursing assessment of an individual's/group's needs for intervention, current nursing knowledge and research
- considers individual/group preferences when determining priorities for care

6.2 Identifies expected and agreed individual/group health outcomes including a time frame for achievement

- establishes realistic short- and long-term goals that identify individual/group health outcomes and specify condition for achievement
- identifies goals that are measurable, achievable, and congruent with values and beliefs of the individual/group and/or significant others
- uses resources to support the achievement of outcomes
- identifies criteria for evaluation of expected outcomes

6.3 Documents a plan of care to achieve expected outcomes

- ensures that plans of care are based on an ongoing analysis of assessment data
- plans care that is consistent with current nursing knowledge and research
- documents plans of care clearly

6.4 Plans for continuity of care to achieve expected outcomes

- collaboratively supports the therapeutic interventions of other health team members
- information necessary for continuity of the plan of care is maintained and documented
- responds to individual/group or carer's educational needs
- provides or facilitates an individual/group or carer's resources and aids as required
- identifies and recommends appropriate agency, government and community resources to ensure continuity of care
- initiates necessary contacts and referrals to external agencies
- forwards all information needed for continuity of care when an individual/group is transferred to another facility or discharged

7. Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health outcomes**7.1 Effectively manages the nursing care of individuals/groups**

- uses resources effectively and efficiently in providing care
- performs actions in a manner consistent with relevant nursing principles
- performs procedures confidently and safely
- monitors responses of individuals/groups throughout each intervention and adjusts care accordingly
- provides education and support to assist development and maintenance of independent living skills



- 7.2 Provides nursing care according to the documented care or treatment plan**
- acts consistently with the predetermined plan of care
 - uses a range of appropriate strategies to facilitate the individual/group's achievement of short and long term expected goals
- 7.3 Prioritises workload based on the individual's/group's needs, acuity and optimal time for intervention**
- determines priorities for care, based on nursing assessment of an individual/group's needs for intervention, current nursing knowledge and research
 - considers the individual/group's preferences when determining priorities for care
- 7.4 Responds effectively to unexpected or rapidly changing situations**
- responds effectively to emergencies
 - maintains self-control in the clinical setting and under stress conditions
 - implements crisis interventions and emergency routines as necessary
 - maintains current knowledge of emergency plans and procedures to maximise effectiveness in crisis situations
 - participates in emergency management practices and drills according to agency policy
- 7.5 Delegates aspects of care to others according to their competence and scope of practice**
- delegates aspects of care according to role, functions, capabilities and learning needs
 - monitors aspects of care delegated to others and provides clarification/assistance as required
 - recognises own accountabilities and responsibilities when delegating aspects of care to others
 - delegates to and supervises others consistent with legislation and organisational policy
- 7.6 Provides effective and timely direction and supervision to ensure that delegated care is provided safely and accurately**
- supervises and evaluates nursing care provided by others
 - uses a range of direct and indirect techniques such as instructing, coaching, mentoring, and collaborating in the supervision and support of others
 - provides support with documentation to nurses being supervised or to whom care has been delegated
 - delegates activities consistent with scope of practice/competence
- 7.7 Educates individuals/groups to promote independence and control over their health**
- identifies and documents specific educational requirements and requests of individuals/groups
 - undertakes formal and informal education sessions with individuals/groups as necessary
 - identifies appropriate educational resources, including other health professionals
- 7.8 Uses health care resources effectively and efficiently to promote optimal nursing and health care**
- recognises when nursing resources are insufficient to meet an individual's/group's needs
 - demonstrates flexibility in providing care where resources are limited
 - recognises the responsibility to report to relevant persons when level of resources risks compromising the quality of care
- 8. Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and interdisciplinary health care team**
- 8.1 Determines progress of individuals/groups toward planned outcomes**
- recognises when individual's/group's progress and expected progress differ and modifies plans and actions accordingly
 - discusses progress with the individual/group
 - evaluates individual/group responses to interventions
 - assesses the effectiveness of the plan of care in achieving planned outcomes
- 8.2 Revises the plan of care and determines further outcomes in accordance with evaluation data**
- revises expected outcomes, nursing interventions and priorities with any change in an individual's/group's condition, needs or situational variations
 - communicates new information and revisions to members of the health care team as required



COLLABORATIVE AND THERAPEUTIC PRACTICE

Relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to the nurse understanding their contribution to the interdisciplinary health care team.

9. Establishes, maintains and appropriately concludes therapeutic relationships**9.1 Establishes therapeutic relationships that are goal directed and recognises professional boundaries**

- demonstrates empathy, trust and respect for the dignity and potential of the individual/group
- interacts with individuals/groups in a supportive manner
- effectively initiates, maintains and concludes interpersonal interactions
- establishes rapport with individuals/groups that enhances their ability to express feelings, and fosters an appropriate context for expression of feeling
- understands the potential benefits of partnership approaches on nurse individual/group relationships
- demonstrates an understanding of standards and practices of professional boundaries and therapeutic relationships

9.2 Communicates effectively with individuals/groups to facilitate provision of care

- uses a range of effective communication techniques
- uses language appropriate to the context
- uses written and spoken communication skills appropriate to the needs of individuals/groups
- uses an interpreter where appropriate
- provides adequate time for discussion
- establishes, where possible, alternative communication methods for individuals/groups who are unable to verbalise
- uses open/closed questions appropriately

9.3 Uses appropriate strategies to promote an individual's/group's self-esteem, dignity, integrity and comfort

- identifies and uses strategies which encourage independence
- identifies and uses strategies which affirm individuality
- uses strategies which involve the family/significant others in care
- identifies and recommends appropriate support networks to individuals/groups
- identifies situations which may threaten the dignity/integrity of an individual/group
- implements measures to maintain dignity of individuals/groups during periods of self-care deficit
- implements measures to support individuals/groups experiencing emotional distress
- information is provided to individuals/groups to enhance their control over their own health care

9.4 Assists and supports individuals/groups to make informed health care decisions

- facilitates and encourages individual/group decision-making
- maintains and supports respect for an individual/group's decision through communication with other members of the interdisciplinary health care team
- arranges consultation to support individuals/groups to make informed decisions regarding health care

9.5 Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security

- demonstrates sensitivity, awareness and respect for cultural identity as part of an individual's/group's perceptions of security
- demonstrates sensitivity, awareness and respect in regard to an individual's/group's spiritual needs
- involves family and others in ensuring that cultural and spiritual needs are met
- identifies, eliminates or prevents environmental hazards where possible
- applies relevant principles to ensure the safe administration of therapeutic substances
- maintains standards for infection control
- applies ergonomic principles to prevent injury to individual/group and self
- prioritises safety problems
- adheres to occupational health and safety legislation
- modifies environmental factors to meet an individual's/group's comfort needs where possible
- promotes individual/group comfort throughout interventions
- uses ergonomic principles and appropriate aids to promote the individual/group's comfort

10. Collaborates with the interdisciplinary health care team to provide comprehensive nursing care**10.1 Recognises that the membership and roles of health care teams and service providers will vary depending on an individual's/group's needs and health care setting**

- recognises the impact and role of population, primary health and partnership health care models
- recognises when to negotiate with, or refer to, other health care or service providers
- establishes positive and productive working relationships with colleagues
- recognises and understands the separate and interdependent roles and functions of health care team members

10.2 Communicates nursing assessments and decisions to the interdisciplinary health care team and other relevant service providers

- explains the nursing role to the interdisciplinary team and service providers
- maintains confidentiality in discussions about an individual/group's needs and progress
- discusses individual/group care requirements with relevant members of the health care team
- collaborates with members of the health care team in decision making about care of individuals/groups



- demonstrates skills in written, verbal and electronic communication
- documents, as soon possible, forms of communication, nursing interventions and individual/group responses

10.3 Facilitates coordination of care to achieve agreed health outcomes

- adopts and implements a collaborative approach to practice
- participates in health care team activities
- demonstrates the necessary communication skills to manage avoidance, confusion and confrontation
- demonstrates the necessary communication skills to enable negotiation
- demonstrates an understanding of how collaboration has an impact on the safe and effective provision of comprehensive care
- establishes and maintains effective and collaborative working relationships with other members of the health care team
- consults with relevant health care professionals and service providers to facilitate continuity of care
- recognises the contribution of, and liaises with, relevant community and support services
- records information systematically in an accessible and retrievable form
- ensures that written communication is comprehensive, logical, legible, clear and concise, spelling is accurate and only acceptable abbreviations are used
- establishes and maintains documentation according to organisational guidelines and procedures

10.4 Collaborates with the health care team to inform policy and guideline development

- regularly consults policies and guidelines
- demonstrates awareness of changes to policies and guidelines
- attends meetings and participates in practice reviews and audits
- demonstrates understanding of the implications of national health strategies for nursing and health care practice

The ANMC acknowledges that the methods and processes in assessment of competencies will be further developed, and that the content of this document will be reviewed in three years. Comments should be addressed to:

The Chief Executive Officer
Australian Nursing and Midwifery Council
PO Box 873
DICKSON ACT 2602

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Glossary of Terms

ANMC: Australian Nursing and Midwifery Council

Appropriate: Matching the circumstances, meeting needs of the individual, groups or situation

Attributes: Characteristics which underpin competent performance

Core Competency Standards: Essential competency standards for Standards registration or licensure.

Competence: The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area.

Competent: The person has competence across all the domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nurse being assessed.

Competency Unit: Represents a major function/functional area in the total competencies of a Registered Nurse in a nursing context representing a stand-alone function which can be performed by the individual.

Competency Element: Represents a sub-function of the competency unit.

Competency Standards: Consists of competency units and competency elements.

Contexts: The setting/environment where competence can be demonstrated or applied.

Cues: Key generic examples of competent performance. They are neither comprehensive nor exhaustive. They assist the assessor when using their professional judgement in assessing nursing practice. They further assist curriculum development.

Domain: An organised cluster of competencies in nursing practice.

Enrolled Nurse: A person licensed under an Australian State or Territory Nurses Act or Health Professions Act to provide nursing care under the supervision of a Registered Nurse. Referred to as a Registered Nurse Division II in Victoria.

Exemplars: Concrete, key examples chosen to be typical of competence. They are not the standard but are indicative of the standard

Registered Nurse: A person licensed to practice nursing under an Australian State or Territory Nurses Act or Health Professions Act. Referred to as a Registered Nurse Division 1 in Victoria.



Appendix 6

List of codes used in the analysis of Clinical Performance Assessment

Tool data

| Code or category | Definition |
|-----------------------------|---|
| <i>Experience group</i> | Used to differentiate between whether the clinical teacher is one that who is classed as either novice or experienced. |
| Novice | Used for a clinical teacher who has less than approximately two years experience with the university and/or clinical teaching |
| Experienced | Used for a clinical teacher who has more than approximately two years experience with the university and/or clinical teaching |
| <i>Comments</i> | Used to class comments made by the clinical teachers on the CPAFs |
| Comments with justification | Comments are made with riders that justify why the comments were made and that support why the comments are being made |
| Comments with explanation | Comments are made with riders that explain why the comments were made or to give more depth to the comments |
| Comments without support | Comments are made but with no supporting evidence to support them, either explanation or justification. These tend to be just heading under which comments about the students ability could be made (but are not) |
| Supportive | These are comments made by the CT's that help or encourage the student in a supportive way. This is different from giving them guidance as to what areas they need to expand their learning in |
| Learning direction | Comments that give the student some direction for learning |
| Negative comments | Code used where the clinical teacher made comments that can be negative in nature and which do not support the student |
| <i>Specific comments</i> | Used for comments that relate to specific areas of practice |
| Medications | Comments that relate specifically to medication management |
| Tasks | Comments that relate to nursing tasks that are not further defined in other sections or just refer to "tasks" |

| | |
|--|---|
| Clinical skills | Comments where the clinical teacher refers to “clinical skills” without further defining them. Also used when the clinical teacher mentions “nursing skills” without further saying what these are. |
| Care planning | Comments that relate to care planning |
| Communication skills | Comments that relate to the student’s communication skills |
| Assessment skills | Comments that relate to the student’s assessment skills |
| Scope of practice | Comments that relate to the student’s understanding of scope of practice and/or their ability to work within their scope of practice |
| IV therapy | Comments that relate various aspects of IV therapy, both theoretical and practical skills (note this may need further breakdown into these two areas) |
| Wound management | Comments that relate to the student’s work in relation to wound management |
| Admission and discharge | Comments that relate to the student’s work in relation to admission and discharge of patients (note this may need further breakdown into various aspects of this work) |
| Handover | Comments that relate to handover processes |
| Teamwork | Comments that relate to the student’s ability to work as a member of a nursing team |
| Technical skills - not specified elsewhere | Used where the CT has mentioned specific technical skills that are not frequently mentioned and/or that relate to more specific nursing skills or actions (ie. care of intercostal catheters) |
| Hygiene care | Comments made about the student providing hygiene care to patients/clients |
| Documentation | Used where the clinical teacher makes a comment about the student in regards to their ability to document information. |
| Evidenced-based practice | Comments made in relation to using evidence to base practice upon. |
| Regulatory aspects | Comments relating to the regulation of nursing practice, ie understanding the requirements for checking of drugs. |

| | |
|-------------------------|--|
| Time management | Comments made about the students ability to manage the timing of care for the patient/s |
| Number of pts cared for | Added to the 4 th set of CPAF's as there were quite a few comments from both novice and experienced clinical teachers about this found in these CPAF's. |

Appendix 7

List of codes used in the analysis of interview and focus group data

| First level code | Second level codes | Third level codes |
|-----------------------------------|---|---|
| Assessment in the clinical field | Comments around course structure | |
| | Feedback to the student by CT's | |
| Clinical teacher workshops | Networking | |
| | Not useful if new | |
| | Suggestions for content | |
| | Talk about problems | |
| | Typical day | |
| | Useful content | |
| CPAF's | Bondy scale | |
| | Formative-summative comments | |
| | | Students comments on formative-summative assessment |
| | Problems with documents | |
| Difficulties with the CT role | Clinical staff not understanding the role of the CT | |
| | Lack of information | |
| | Need for more support | |
| | Spread thin | |
| Experience | Higher Education | |
| | Other | |
| | Preceptor | |
| | TAFE VE | |
| Hospital staff | Communication | |
| | Feedback | |
| | Making use of staff | |
| | Relationships | |
| Overcoming problems with students | Communication to the student | |
| | Debriefing sessions | |
| | Understanding diversity | |

| First level code | Second level codes | Third level codes |
|-------------------------------|--|-------------------|
| | Using academic staff for issues | |
| | War stories | |
| | Working with students | |
| Preparation | Initial problems with being a CT | |
| | No preparation | |
| | Preceptor workshop | |
| | Working as a lab facilitator | |
| Problems with students | Aged care | |
| | Attitudes | |
| | Lack of skills-knowledge | |
| | Misconceptions | |
| | Strange environment | |
| | Uniforms | |
| Qualifications | Cert IV in workplace assessment and training | |
| | Informal preparation | |
| | Masters degree | |
| | Needing a qualification | |
| | Other | |
| | Students views on qualifications | |
| Role of the CT | Facilitation | |
| | Identify problems | |
| | Students view | |
| | Support | |
| Second round of CT interviews | Assessment role | |
| | CT workshops | |
| | CT's and patient allocation | |
| | CT's views on how the clinical staff view them | |
| | Describe role of CT to somebody new | |
| | Preparing for the role | |
| | Educative role | |
| | Facilitative role | |
| | Giving feedback to students | |

| First level code | Second level codes | Third level codes |
|---------------------------------|--|-------------------------------|
| | | Summative assessment comments |
| | Hidden roles | |
| | Knowing theory students have been taught | |
| | Managing people | |
| | Mothering-nurturing | |
| | Other terms for role | |
| | Professional development | |
| | Their future development in the role of a CT | |
| | Using teaching material in clinical | |
| | Work since last interview | |
| Students views | | |
| | Attributes of a idea CT | |
| | Differences in practice | |
| | Experience of the CT in the area student is in | |
| | Helpful actions by the CT | |
| | Knowledge needed by the CT | |
| | Skills needed by the CT | |
| | | Advocate for students |
| | Unhelpful actions by CTs | |
| Things that help in the role | | |
| | Experience | |
| | Put yourself in their shoes | |
| Things that hinder in this role | | |
| | Clinical problems that impact on role | |
| | Clinical staff's views of students | |
| | Experience | |
| | Other CT's | |
| | Processes | |
| | Reluctant students | |
| | Time | |