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The Steering Towards Readiness Framework

The lived experience of clinical facilitators in identifying, assessing and managing students at risk of not being ready to practice as beginning practitioners within Western Australian health settings

Rosealie Southwell

RN, Post Graduate Diploma

Submitted in fulfilment of the requirements for the
Doctor of Nursing



School of Nursing

Fremantle Campus

November, 2019

Declaration

To the best of the candidate's knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made.

This thesis is the candidate's own work and contains no material which has been accepted for the award of any other degree or diploma in any institution.

Human Ethics (For projects involving human participants/tissue, etc) The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the University Of Notre Dame Australia Human Research Ethics Committee, Approval Number #014109F

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Abstract

Clinical facilitators (CFs) are a fundamental resource for student registered nurses (RNs) as they facilitate the consolidation of theory and practice in preparation for registration with the Nursing and Midwifery Board of Australia (NMBA). Health service providers (HSPs) and higher education providers (HEPs) require CFs to identify, assess and manage (I, A & M) the risks of final placement nursing students and, in doing so, protect risk to patient safety. This research aimed to explore the lived experience of CFs in Western Australia in identifying, assessing and managing risk of a student progressing to be a RN. The study used an interpretative phenomenological approach with Heideggerian hermeneutical principles and commentary to guide the exploration and analysis of nine in-depth interviews with CFs. Follow-up interviews substantiated the initial findings.

The five major themes identified were ‘The contexts’ of the HSPs’ and CFs’ toolboxes; the CFs’ ‘Responses to navigating current conditions’; and three phases of a final placement: termed ‘Navigating current traffic conditions’, ‘Forging ahead’ and ‘Reaching the destination’. The findings revealed how participants took this journey not only with students, but with other nurses, academics and colleagues. The Steering Towards Readiness framework developed during the study highlights how CFs rely on themselves and/or on other nurses to support students on a final placement. Students were identified as not being independent in the workplace and ready only with support. Further debriefing for CFs to better I, A & M risk was needed.

This research used an innovative approach to describe how the contexts, resources and attributes of nurses, students and CFs influence how risk to student readiness is identified, assessed and managed on a student’s final placement. The study paves the way for an examination of the likelihood of risk and possible strategies to actively engage the CF in a cooperative relationship with educational and health setting providers. Such a relationship may assist in the graduation of industry-ready and capable graduates.

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I would especially like to thank my supervisors Professor Selma Allix and Professor Kylie Russell. Their teamwork and collegiality enabled this journey. They both believed in my ability, encouraged me and gently guided me when I was confused or unsure. I am filled with gratitude for this opportunity to have been guided by you.

I would also like to acknowledge the University of Notre Dame staff who gave me their support during this time of learning and discovery and who reviewed my thesis. This support enabled me to focus on the research, helped me to write up my proposal more effectively and refine the final output. These individuals included the research team, tutors and those who critiqued my initial presentation: Dianne Chambers and Sheila Gibb-Martin. To my participants, you have provided valuable insight and have expanded my understanding about the difficulties you have experienced. Without you, this study would not have been possible.

To my family and friends, thank you for taking a ‘back seat’ while I pursued my goals. To Peter Millington, your advice and comments were greatly appreciated. To my husband Bob, your untiring support, love and encouragement was unwavering throughout this time. My life is richer because you have lived, and because you have loved me.

Prologue

This prologue is included to explain why this study was undertaken. Prior to 2007 I felt there was no benefit to me undertaking tertiary study. After all, I was getting well paid to be a RN. However, more and more I found patients asking, ‘Will you please look after me tomorrow?’ Seeing panic in their expressions caused me distress. I found that workplace nursing practices were questionable as patients needed more nursing care than they were being given.

This and other factors led me to undertake further study so that in the future I could influence how nursing care was practised. On commencing studies at university, I also began a new job as a CF. I was given some material to read and the clinical director was supportive but there were few standardised tools to assist in managing students.

I found myself in many different workplaces and saw that at times nursing students were not wanted, not supported and unfairly treated. When students were valued by nursing staff, nursing staff also valued my support and worked with me to support students. I quickly learnt that I needed to develop my own set of tools or processes for evaluating how students were progressing and identifying those at risk. The process of clinical facilitation was an art that took time to develop. I wished there were more resources to support me in my role.

This study came about as I often felt that although CFs were valued, the university and CFs were reported in the literature as key contributors to students not being adequately prepared for the workplace. However, my experiences told me that the HSPs were also responsible. I found that I utilised learning contracts as a way to hold health service staff accountable for supervising students and as a way to protect students from being unfairly evaluated; what I didn’t know was whether I was alone in this experience. I wondered if other CFs felt the same way or if they had different ways of managing risk. I felt the topic was important.

My philosophical position is that we are all influenced by what has happened to us and by how we then choose to act. Having a viewpoint does not mean the view is representative of reality. It is only when we take the time to sift through varying perspectives and evidence that we are better able to judge the validity of our

viewpoints. To this end I chose an interpretative approach as it would help me make sense of not only my own experiences, but those of the participants. It is my participants' experiences that outline how risk is managed and inform those who wish to seek further answers.

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Operational Definitions

Assistant in nursing (AIN): An unregulated caregiver who assists the nurse by providing basic nursing care.

Assessing risk: The process of discovering, noticing or linking risk with individuals who are likely to be at risk.

Clinical facilitation. The actions of providing support to both clinical supervisors (CSs) and student nurses, which may consist of teaching, undertaking assessments and providing feedback (Health Workforce Australia [HWA], 2010).

Clinical facilitator (CF): A registered nurse (RN) with a background in nursing education. They may be employed by a higher education provider (HEP) or health setting to facilitate nursing students learning in their clinical practice, and to support student supervisors. Within the higher education and healthcare sectors, the terminology for this role varies (HWA, 2011a): clinical educator, clinical instructor, clinical tutor, link lecturer, field supervisor, practice teacher, clinical supervisor and clinical educator.

Clinical learning environment (CLE): The interactions and resources within the clinical setting that influence students' learning outcomes.

Clinical placement/practicum: The component of nursing education that allows nursing students to put their theoretical knowledge into practice within the patient/client care environment to 'build knowledge, skills and attributes essential for professional practice' (HWA, 2011a, p. 3). The term is interchangeable with clinical rotation, depending on terms used by HEPs (Department of Health & Human Services, 2009).

Clinical supervision: 'This involves the oversight—either direct or indirect—by a clinical supervisor of professional procedures and/or process performed by a student or a group of students within a clinical placement for the purpose of guiding, providing feedback on, and assess personal, professional and education development in the context of each student's experience of providing safe, appropriate and high quality patient care' (HWA, 2011a, p. 4).

Clinical supervisor (CS): The RN who works alongside one or more students to provide nursing care to a group of patients. They model behaviour for each day of their clinical placement. Terminologies used for the supervising role on each shift are preceptor, buddy, mentor or supervisor. A CS may/may not be the person designated for overseeing a student's practice for their entire placement.

Competency: The necessary level that students must demonstrate in the combination of skills, knowledge, attitudes, values and abilities for practice (NMBA, 2015) and as determined by the HEP assessment schedule.

Enrolled nurse: A nurse who has completed diploma or hospital training as an enrolled nurse, who provides nursing care as delegated by the RN, and who is registered with the Australian Health Practitioner Regulation Agency (AHPRA).

Final practicum/placement: The final placement or placements for clinical practice of a final-year student.

Health service provider (HSP): A health setting organisation that provides services for the clinical placement opportunity. It is also the setting in which nursing care is provided. This setting involves systems, workforce, policies and the approach to provision of care. Health settings relate to the working environment, the staffing mix, the culture, the models of care and patient care.

Health service staff (HSS): Nursing managers, RNs and other nursing staff such as ENs and AINs.

Higher education provider (HEP): A university or other tertiary education institution that provides nursing education. Other terms used synonymously with HEP are tertiary provider, university or university setting.

Identify, Assess & Manage (I, A & M): The process required to identify risk, assess risk and to manage risk. Synonymous terms used are identifying, assessing and managing which are not abbreviated.

Identifying risk: The process of noticing, finding out or linking the risk with individuals likely to be at risk.

Assessing risk: The process of determining the scope of risk and making a decision as to what can be done to reduce the risk.

Managing risk: The process of developing a plan of action to mitigate the risk and to monitor the outcome.

National Competency Standards for the Registered Nurse: The RN Standards developed by the NMBA to assess a student nurse or registered nurse's competence to practice (NMBA, 2006).

Nursing and Midwifery Board of Australia (NMBA): The regulator of nursing and midwifery practice in Australia to protect the public. The board develops safe practice of nurses by developing registration and practice standards, professional codes, and guidelines for practice.

Nursing Competency Assessment Schedule (NCAS): The national assessment tool developed to assess Australian nursing students' level of practice against the RN Standards.

Readiness to practice: A student nurse's ability to demonstrate safe and competent nursing care at a graduate level as set out by the Standards for Australian RNs.

Registered nurse (RN): A nurse who has completed the learning requirements from a HEP or the equivalent training from a recognised hospital-based program, and who is registered with the Australian Health Practitioner Regulation Agency (AHPRA).

Registered Nurse Standards for Practice: The current Standards (NMBA, 2016) developed by the NMBA to assess students and registered nurse's competency and to expand capability. These Standards have replaced the *National Competency Standards for the Registered Nurse (2006)*.

Risk: A situation exposing the student to failing the practicum, or to a patient being exposed to unsafe nursing care.

Specialty: Any approach used for nursing. Specialty areas include acute (both medical and surgical areas), medical, surgical, general practice, intensive care unit (ICU),

coronary care unit, theatre, emergency department, palliative care, rehabilitation school nursing, community nursing, mental health, paediatric and maternity nursing.

Stakeholders: Groups or individuals such as HEPs, academic staff, students, HSPs and HSS, who invest their time in nursing education.

Student nurse: A person undertaking education and training in a clinical placement within the health services (HWA, 2011a, p. 4) who on successful completion will be entitled to register with the AHPRA.

Supervisor: A CF, CS, mentor or preceptor.

Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
ADDS	Adult Deterioration Detection System
AHPRA	Australian Health Practitioner Regulation Agency
AIN	Assistant in nursing
ALTC	Australian Learning and Teaching Council
ANSAT	Australian Nursing Standards Assessment Tool
ANTT	Aseptic non-touch technique
ASAP	Amalgamated Student Assessment in Practice
BN	Bachelor of Nursing
BPCF	Best practice in clinical facilitation
BPCLE	Best practice clinical learning environment
CALD	Cultural and language diversity
CF	Clinical facilitator
CI	Clinical instructor
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CLE	Clinical learning environment
CS	Clinical supervisor
DEU	Dedicated Education Unit
DOH	Department of Health
EN	Enrolled nurse
ESL	English as a second language
HDC	Hermeneutical Development of Commentary
HEP	Higher education provider
HPR	Hermeneutic principles for research

HREC	Human Research and Ethics Committee
HSP	Health service provider
HSS	Health service staff
HTMETS	Heidegger's three (unsettled) modes of existing or 'taking a stand'
HWA	Health Workforce Australia
I, A & M	Identify, assess and manage
IPA	Interpretative phenomenological approach
LDP	Learning and development plan
MeSH	Medical subject headings
NCAS	<i>Nursing Competency Assessment Schedule</i>
NESB	Non-English-speaking background
NMBA	Nursing and Midwifery Board of Australia
NSW	New South Wales
NUM	Nursing unit manager
NZ	New Zealand
RN	Registered nurse
SDN	Staff development nurse
STR	Steering Towards Readiness
TAFE	Technical and Further Education
WA	Western Australia
WHO	World Health Organization

Chapter 1: Introduction

1.1 Background

Health Workforce Australia (HWA) was developed in 2010 to address the sustainability of a health workforce that was skilled to meet and adapt to the healthcare of Australians and provide an analysis of the workforce (HWA, 2014a). A 2014 report on the Australian nursing workforce (HWA, 2014a) revealed that the attrition rate of student nurses was 34%. Moreover, the expected shortfall of both registered nurses (RNs) and enrolled nurses (ENs) in 2030 is predicted to reach almost 123,000. To manage the increasing deficits in skilled nurses, the employment of assistants in nursing (AINs) and patient care assistants has increased (HWA, 2014a).

The HWA's (2013) *National Guidelines for Clinical Placement Agreements* outlined the responsibility of health service providers (HSPs) and higher education providers (HEPs) to provide students with learning opportunities in environments that were safe and appropriately resourced. Organisations are expected to identify, assess and manage (I, A & M) perceived threats to individuals or organisations from the decisions or actions taken within the system (Western Australia Department of Health [WA DOH], 2016). To ignore risks would negate the profession's responsibility to provide adequate training to students. Further, in the light of workforce shortages and increasingly complex patient health needs, managing risks during student praxis increases the likelihood that graduates will be work ready (HWA, 2013).

Scaffolded opportunities for practice enable students throughout their training to become ready for the role of the RN (Needham, 2014). This experience helps students to consolidate their learning (Needham, 2014), link their knowledge to real-life situations and become prepared for the role of the RN (Hathorn, 2006). The student nurse on their final placement is expected to demonstrate practice at a beginning RN level that complies with Nursing and Midwifery Board of Australia (NMBA) standards (NMBA, 2016). The following background section expands on the models that support student opportunities to practice, the attributes of the clinical learning environment (CLE) and what it means to be ready for practice.

1.1.1 Models Supporting Clinical Learning

This section describes how placements provide clinical learning opportunities for students. The clinical facilitator (CF) works with the enabling or hindering factors associated with the current models. The three models described in the literature are the ‘model for placements’, ‘models of patient care’ and ‘models for supervision’.

1.1.1.1 Model for Placements

The scaffolding of learning occurs in a variety of clinical settings, and students’ learning mostly occurs in acute, mental health, aged care, primary care or community health or general practice settings (HWA, 2014b). Training can occur in various locations: the city, inner to outer regions and remote regions (HWA, 2014b). Students aim for a final practice in an acute hospital. However, such placements are becoming limited and there is an increasing trend for students obtaining opportunities for practice in the general community (National Health Workforce Taskforce, 2009). Most placements occur in the acute setting (HWA, 2014b). Patient care and supervision of students can be influenced by the specialty type, location and type of agreement made between HEPs and HSPs and the length of placement. The framework known as models of patient care explains how patients will receive their nursing care across these areas of practice.

1.1.1.2 Models of Patient Care

Having new graduates ready to manage a group of patients has commonly been accepted as part of their role (Haddad, 2016; Woods et al., 2015). The expectations are that nursing care will be delivered safely (Australian Learning and Teaching Council [ALTC] & HWA, 2016). Models of nursing care explain the delivery and allocation of patient care (Hayward, 2009). Four frequently adopted international models of care include the task or functional nursing model, the patient allocation model, the team nursing model (New South Wales Department of Health [NSW DOH], 2011) and the primary nursing model (Haywood, 2009; Duffield, Roche, Diers, Christine, & Blay, 2010). In Western Australian acute care settings, the models of care utilised are the patient allocation and team nursing models.

1.1.1.2.1 Task Nursing

The task or functional nursing model is ‘described under the headings of task allocation and hierarchical nursing’ (Haywood, 2009, p. 8). Adams, Bond and Hale’s definition of this model (as cited in Haywood, 2009) defines task allocation as the performance of ‘distinct’ tasks by a nurse, delegated according to the nurse’s length of service. This model does not provide an efficient way for nurses to have an overall view of the patient’s condition. However, Haywood (2009) opined that this model is still useful when a crisis occurs and where individuals perform the tasks necessary to manage the emergency.

1.1.1.2.2 Patient Allocation

The patient allocation model involves the distribution of patients among a group of nurses with each responsible for their own group of patients for that particular shift (Haywood, 2009). Distribution is based on the skill set of each nurse and the complexity of each patient’s nursing needs. This model allows the most experienced nurses to look after the most acute cases and, regardless of the skill, each nurse manages for the holistic, patient centred or total care of their patient’s needs (Alderman, 2017; Duffield et al., 2010).

1.1.1.2.3 Team Nursing

The team nursing model of care provides patient care within a team of nurses who share the assessment, planning, evaluation and allocation of tasks for a group of patients (Ferguson & Cioffi, 2011). The team may include nursing assistants who undertake lower-level tasks (Hayward, 2009). This model relies on a senior or more experienced RN to support junior RNs, ENs and AINs. However, the authors considered that the configuration of the team can vary with the needs of the ward or unit: there should always be a RN who is clinically competent to perform the team leader role (NSW DOH, 2011). The team nursing model is a hybrid model and, as described by the NSW DOH, can be referred to as a collaborative nursing model (NSW DOH, 2011). This extension of the team approach allows for a skill mix of staff with varying levels of expertise to provide a group of patients with the right person or skill to provide patient-centred care (NSW DOH, 2011).

1.1.1.2.4 Primary Nursing

Primary nursing, also referred to as the case management model, incorporates nursing staff who regularly manage the care of one or more patients, which allows for the continuity of care. When the nurse is not on duty to manage this patient, another nurse will take over this care and the plan developed by the primary nurse continues. This model is frequently used in the community setting, is considered ‘holistic’ or patient centred, and includes families and caregivers in the decision-making process (Hayward, 2009).

This overview of models of nursing care utilised in healthcare settings highlights the complex and changing environment that students and CFs enter. Students and CFs need an understanding of these different models to facilitate a smooth orientation into the team to allow learning and assessment to commence soon after. The next type of model describes the supervision of nursing students.

1.1.1.3 Models for Supervision

Both HEPs and HSPs are responsible for ensuring that there is appropriate supervision for student learning. This support assists students in achieving competency and capability as determined by the NMBA in the *Registered Nurse Standards for Practice* (NMBA, 2016). Supervisors must be qualified, prepared, utilise contemporary evidence-based practice and understand international perspectives on nursing practices (HWA, 2014a). Both providers should enable ‘clinical education to be valued, supported and recognised’, and facilitate ‘collaborative relationships among participants, including the health and education sectors, and within and among professions’ (HWA, 2013, p. 6).

Models utilised in Australia for undergraduate nursing students include the clinical supervisor (CS), the clinical facilitator (CF) and the Dedicated Education Unit (DEU) (HWA, 2010). Although the literature identifies enablers and barriers for each model of supervision, the HWA (2013) did not seek to endorse a particular model but instead undertook to provide broad guidelines to support organisations developing and using clinical placement agreements. In Western Australia (WA), the most common models used for students on final placements are the CS and CF models.

1.1.1.3.1 Clinical Supervisor Model

The first model widely recognised was the CS, preceptor, buddy, mentor or supervisor model (Brammer, 2008; HWA, 2011; McCarthy & Murphy, 2008; Spouse, 2001). In this model, a RN will supervise a student on a 1:1 basis in a health setting for the period during which students are working in a health setting and will undertake student assessments (HWA, 2011; Sedgwick & Harris, 2012). This role is considered essential for socialising nursing students into the role of a professional nurse (Deasy, Doody, & Tuohy, 2011). However, the current trend is for a buddy ‘nurse of the day’ rather than that of a dedicated preceptor to be utilised for the period of the placement. HWA defined this role as:

involving the oversight—either direct or indirect ... of professional procedures and/or processes performed by a student or a group of students within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each student’s experience of providing safe, appropriate and high-quality patient care (HWA, 2011a, p. 4).

For this study, the role of the CS is treated as distinct from the role of the CFs.

1.1.1.3.2 Clinical facilitator model

The CF is known by various names: the clinical educator (Deegan, Burton & Rebeiro, 2007), clinical instructor (CI) (HWA, 2011), link lecturer (Hunt, McGee, Gutteridge, & Hughes, 2016a; 2016b), mentor, practice partner (Needham, 2014), CS (Russell, Hobson, & Watts, 2010), field educator or clinical tutor (HWA, 2011). HWA (2010) defines the term ‘facilitator’ as a RN, who is ‘a supernumerary supervisor typically responsible for a group of eight nursing students during students’ clinical placement’ (p. 48).

Facilitation employment variations will be agreed between HEPs and HSPs. CFs may be academic or health service staff (HSS) and may be employed either full time, for sessional periods or seconded from the HSS (Henderson, Twentyman, Heel, & Lloyd, 2006; Nash, 2007). The CF will usually spend an hour per day with each student (Black, 2011) and will verify and report on how the student demonstrates the practices of the *Registered Nurse Standards for Practice* (NMBA, 2016).

1.1.1.3.3 Dedicated Education Unit

The DEU (HWA, 2010) or Clinical Education Unit (CEU) (Nash, 2007) is a model that emphasises collaboration and ‘commitment to a positive learning environment’ (Nash, 2007, p. 61). In this model, a clinical associate and a clinical partner from the designated placement area will support the student by having placements that are annually consistent (Nash, 2007). Also, the use of academic support or a liaison person from the HEP is utilised to extend support. However, in the WA health setting, the DEU or CEU model has not been utilised. In addition to the models used for supervision, the attributes of the CLE will influence how students are enabled or hindered.

1.1.2 Attributes of the Clinical Learning Environment

Best practice clinical learning environments (BPCLEs) include features of ‘a positive learning environment’, ‘an organisational culture that values learning’, ‘effective communication processes’, ‘an effective health service–educator provider relationship’, ‘best practice clinical practice’ and ‘appropriate resources and facilities’ (Department of Health & Human Services, 2009). However, these features are a result of the individual and organisation attributes, the students, the individual nurse supervisors and the workplace.

1.1.2.1 Student Attributes

Students’ personal and professional attributes appear to influence how effective students can become prepared for the role of the RN. These factors are related to their backgrounds or personal attributes. Student background factors include educational pathways (Deegan et al., 2007) and cultural and language diversity (CALD) (Alderman, 2017; Deegan et al., 2007; Jeong et al., 2011; Sherman & Eggenberger, 2008; Zilembo, 2008). Personal attributes have been seen as the coercive nature of students (Hunt et al., 2016a) and their poor behaviours or attitudes (Black, 2011; Killam, Montgomery, Luhanga, Adamic, & Carter, 2010). However, the attributes of students’ work readiness can be measured through social intelligence, personal work characteristics, organisational acumen and work competence. Walker, Storey, Costa and Leung (2015) confirmed that these additional attributes were additional to clinical or technical competence. The CFs’ or supervisors’ understanding of both the students’

background and health setting variables may influence how they can I, A & M issues associated with work readiness.

1.1.2.2 Supervisor Attributes

CFs and CSs are essential for providing the best environment for overseeing learning and clinical progression (Department of Health & Human Services, 2016a; McAllister, Nagarajan, Scott, Smith, & Thomson, 2018; Price, Hastie, Duffy, Ness, & McCallum, 2011). Best practice in clinical facilitation (BPCF) outlines the CF's role (Needham, 2014) and the core skills necessary for the role (World Health Organization [WHO], 2016). As the working culture within the health setting or organisation will influence student practice (Kube, 2010), the CF's level of understanding of these factors may have some bearing on the timely identification and management of struggling students. Their timely identification lowers the risk to patient safety and ensures students have both the time and the support to demonstrate they are competent (Skingley, Arnott, Greaves, & Nabb, 2007).

Evaluation of the student is undertaken by the CF when they visit the student and the designated HSS during the student's placement. However, some attributes of the CF and HSS are seen to hinder students (Killam et al., 2012; Killam, Mossey, Montgomery, & Timmermans, 2013). RNs may not have a shared understanding of the RN Standards (Cashin et al., 2017; Terry, 2013). They may not have guidelines on how to assess student competency for safe patient care (Levett-Jones et al., 2017). Moreover, Brown and Crookes (2016a) appeared disturbed by the diversity of skills that were taught by HEPs and the lack of consensus regarding what skills were necessary on completion of training. This lack of consistency results in variation in how students are 'work ready' (Brown & Crookes, 2016a).

Throughout Australia, different assessment tools are used by HEPs. Some tools assess and pass students on safe practice rather than independent practice (Griffith University, 2014; Zasadny & Bull, 2015). Further information about how CFs I, A & M the risk to a student's professional development will provide valuable insight into the political nature of facilitation.

1.1.3 Attributes of the Workplace

The attributes of the workplace include factors that influence the readiness of students (Price et al., 2011; Reid-Searl, Moxham, Walker, & Happell, 2009). Such factors are a lack of supervision and a culture of unsafe workplaces (Lockwood, 2009; Zilembo & Monterosso, 2008). Underlying these risks is whether a student felt as though they were accepted and could become competent in their nursing practice (Levett-Jones, Lathlean, Higgins, & McMillan, 2009). However, when the practice is less than best, this striving may place students more at risk of providing unsafe nursing care (Levett-Jones & Lathlean, 2008). Hanson and McAllister (2017) suggested that guiding students in the skills of doing, being, realising, critiquing and visioning can help them to reframe and reflect on the stressors they face in the CLE.

1.1.4 Ready for Practice

‘Ready for practice’ is one of the terms used to convey the idea that a student is now ready to register with the Australian Health Practitioner Regulation Agency (AHPRA). Other terms used in the literature are ‘beginning level’, ‘entry level’, ‘graduate level’, ‘work ready’ and ‘fit for practice’. For this study, the terms ‘readiness’, ‘readiness for practice’ or ‘ready for the role of the RN’ are used. Final consensus on what it means for students to have a ‘readiness to practice’ has not been reached by regulatory bodies, HEPs and nursing professionals (Wolff, Pesut, Regan & Black, 2010).

Nursing professionals have varying expectations about students’ work readiness when first employed. One expectation in dispute is that students should be able to ‘hit the floor running’ (Levett-Jones, 2007; Wolff et al., 2010). In Wolff et al.’s conclusion, ‘work readiness’ was defined as:

Readiness for practice means that new graduates attain entry-level competencies that prepare them for a global world as well as some job-specific capabilities to meet immediate workforce needs. Next, readiness for practice means that new graduates are competent to provide safe client care in the context of today’s realities as well as adapting to new and changing circumstances in healthcare, nursing and the provision of client care. Readiness also means that new graduate nurses possess

a balance of doing, knowing, and thinking to ensure safe care (Wolff et al., 2010, p. 9).

Australia's guiding standards are set out by the NMBA (2016). These standards do not state what 'readiness to practice' means. For this study the definition of 'readiness' or 'readiness for practice' was derived from the RN Standards. Student nurses have a readiness to practice when they have successfully demonstrated they can provide safe and competent nursing care as set out by the NMBA (2016) standards:

Thinks critically and analyses nursing practice, engages in therapeutic and professional relationships, maintains the capability for practice, comprehensively conducts assessments, develops a plan for nursing practice, provides safe, appropriate and responsible quality nursing practice and evaluates outcomes to inform nursing practice (pp. 1–2).

Wolff et al. (2010) defined graduate 'readiness' as having a generalist foundation with some specific job capabilities related to areas such as acute, residential, community or mental health. Readiness was also equated to the provision of safe client care by following standards, seeking assistance, preventing harm and being aware of the principles associated with nursing care (Wolff et al., 2010). Students would be ready if they could balance the doing, knowing and thinking associated with the provision of nursing care and deliver nursing care that was current practice (Wolff et al., 2010).

A student should demonstrate competent nursing skills and professionalism during each period of clinical practice throughout their training, as measured by the *Registered Nurse Standards for Practice* set out by the NMBA (2016). Regular assessment of the student's ability to achieve these standards ensures that the student is becoming competent in their nursing practice.

If students can demonstrate these standards, they are considered 'fit for practice' and are ready to practice as a RN (Grant, Leigh, Murray, & Howarth, 2007; Gregory, Guse, Dick, Davis, & Russell, 2008; Wolff et al., 2010). However, students who struggle to demonstrate competence are considered unfit for practice and will increase the risk of adverse events such as compromising patient safety (Gregory et al., 2008). As the identification, assessment and management of risk occurs in a shared context, further

insight about how the CF engages with others will provide further understanding about student readiness.

1.2 Research Aim

The main aim of this study was to explore the lived experience of CFs through in-depth interviews about how they had identified assessed and managed factors that placed students at risk of not being ready for beginning professional nursing practice. A secondary aim was to examine the findings in relation to five key theories: Katz and Kahn's (1978) Open Systems Model, Heron's Facilitation Theory (Heron, 1999), Bloom's Taxonomy as illustrated by Henry and Murry (2018), the Approaches to Risk (WA DOH, 2016) and the Ascent to Competency model (Levett-Jones, 2007). The final aim of this study was to provide key recommendations for providers and CFs that will increase the quality of the identification, assessment and management process for final placed nursing students.

1.3 Research Questions

The research questions for this study were:

1. What are clinical facilitators' perceptions of the factors that may affect the final-semester nursing student's ability to be ready for the role of the registered nurse?
2. How do clinical facilitators identify, assess and manage perceived factors that hinder the final-semester nursing student's ability to be ready for the role of the registered nurse?

1.4 The Potential Significance of this Study

The literature highlights the numerous issues that affect students' clinical learning. These can occur at any time throughout their training. Struggling students' issues have been related to poor supervisory relationships with supervising nurses (Amicucci, 2011; Deegan et al., 2007; McGregor, 2007). Poor supervisory relationships may result from a lack of supervisor preparation (Amicucci, 2011; Henderson et al., 2006). Another identified factor is the poor attitude or behaviour of a student (Luhanga, Myrick & Yonge, 2010; Luhanga, Yonge & Myrick, 2008). Five areas of concern were

identified in relation to clinical workplaces: a stressful environment (O’Driscoll, Allan & Smith, 2010); poor workplace culture (Zilembo & Monterosso, 2008); lack of ethical and professional accountability (Luhanga, Myrick & Yonge, 2010; Tanicala et al., 2010); ambiguity within roles (O’Driscoll et al., 2010); and lack of student supervision within the clinical placement (Brammer, 2008; Jacob, Sellick, & McKenna, 2012; Reid-Searl & Happell, 2012).

Research has also highlighted the diversity of the educational entrance or pathway into nursing (DOH, 2013). A student’s background and working history may also affect how they undertake praxis within a clinical placement (Deegan et al., 2007). CALD can hinder student learning because such students struggle with communication and socialisation barriers (Edgecombe, Jennings & Bowden, 2013). The risk of students failing and being unable to meet readiness for practice has not been fully explored regarding the student’s background and factors related to the health setting. As the role of the CF is to I, A & M student issues, it is the CF who can shed some light on what their lived experience of the phenomenon means.

The lived experience is potentially significant not only for CFs but also for students and HSS. This study aimed to highlight how CFs perceive they can perform their role in providing learning opportunities for students to provide safe and competent care, how they I, A & M risk, and what they perceive to be the barriers and enablers to I, A & M risk to readiness. The complexity associated with the identification, assessment and management of risk will provide further insight into how students may graduate at the independent level of a beginning RN. In addition, new insight with regard to the chosen theories will add to knowledge on how the identification, assessment and management of risk occurs. These insights or adaptations of the chosen theories are expected to be relevant to other researchers who wish to review, test or expand on these explanations. This study was undertaken within the Western Australian context and therefore is limited to this setting.

1.5 The Organisation of the Thesis

In this first chapter, the overview, background and topic information, purpose and significance of the study and the operational definitions have been introduced. The guiding research questions for this study were provided. Chapter 2 provides a brief

literature review to demonstrate to the reader the complexity of the CLE and its effect on student learning in a final clinical practice. Further, the chapter describes relevant theories that may explain the phenomenon. Chapter 3 outlines the theoretical approach and the research methods used for this study. Chapter 4, 5 and 6 present the findings of the study. Chapter 7 provides a discussion on the implications of the findings with reference to the current literature, theories and earlier research findings. Chapter 8 includes a conclusion that draws upon the discussion surrounding the identification, assessment and management of students on a final practicum. Chapter 8 also provides recommendations that arose as a result of this study. Limitations of the study are also described.

1.6 Chapter Summary

The aim of Chapter 1 was to establish the background to the study. The research aims and questions were described. Factors that hinder the development of student readiness are significant for student development and readiness. Factors that hinder the identification, assessment and management of risk during a student's final practicum are relevant to organisational providers and other nurses. The chapter concluded by outlining the organisation of the thesis. The next chapter reports on the literature review.

Chapter 2: The Literature Review

2.1 Introduction

Chapter 1 provided background information about nursing education and learning, which culminates with a final clinical practice placement. The purpose of this study was to explore the lived experience of CFs through in-depth interviews on how they had identified, assessed and managed factors that placed students at risk of not being ready for beginning professional nursing practice. The outcomes of this study have implications for CFs who are key personnel in supporting students.

This chapter reviews contemporary literature on the enablers and barriers to student learning and how the CF can support students in the CLE. This review focusses on the critical aspects of identification, assessment and management that may occur in final-semester nursing placements. The gaps or limitations in the current literature are identified. The chapter also provides an overview of the theories relevant to the phenomenon of identifying, assessing and managing risk to student competency on a final placement. The conceptual framework in Figure 1 provides an outline of the concepts related to the pertinent literature review.

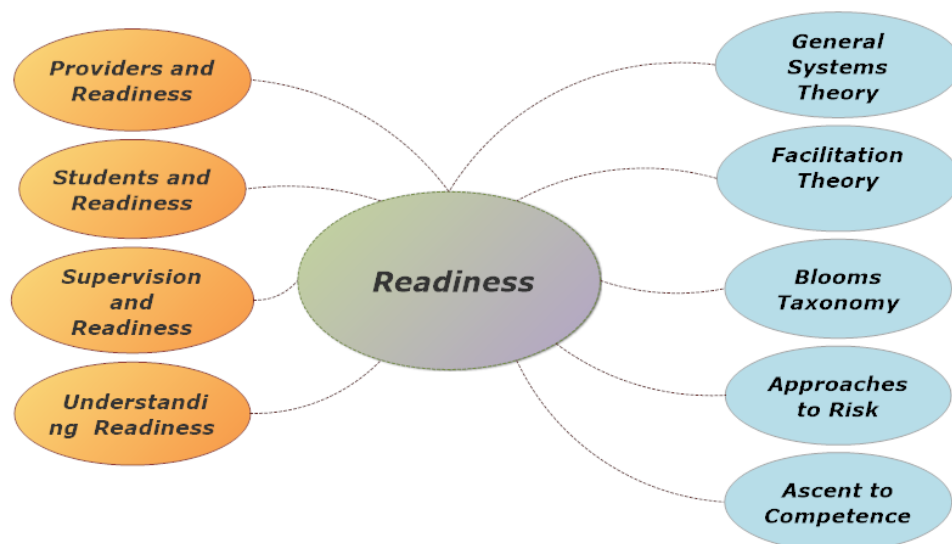


Figure 1: A conceptual framework for examining the literature

2.2 The Search Strategies

The first step in the search strategy was to pose two specific questions that would ensure that the appropriate literature was accessed. These were, 'How are students supported in becoming ready for practice?' and 'How are failing students managed to become ready for practice?'. The focus of the literature review was to extend the understanding of current issues facing Australian nursing facilitators and the development of student competency. Keywords used to initially search for literature included 'nursing students', 'legal issues related to the failure', 'clinical learning environment', 'student supervision', 'Australia', 'unsafe undergraduate nursing students' and 'preparedness'. However, May and Black (2011) reported that it could be difficult for researchers to identify appropriate search terms. The terms making up the mnemonic of ECLIPSE ('Expectation', 'Client group', 'Location', 'Impact', 'Professionals', 'Service') were therefore utilised in a variety of combinations to determine the medical subject headings (MeSH) that would further guide the search for health and social care (Wildridge & Bell, 2002).

Scholarly databases were accessed to obtain literature ($n = 651$) published for a 10-year period between 2008 and 2018. These articles were obtained from the Cumulative Index to Nursing and Allied Health Literature (CINAHL with full text) ($n = 323$), EBSCO ($n = 28$), Scopus ($n = 28$), PubMed ($n = 136$), Science Direct ($n = 100$) and Web of Science ($n = 36$); see the PRISMA flowchart (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009) in Figure 2.

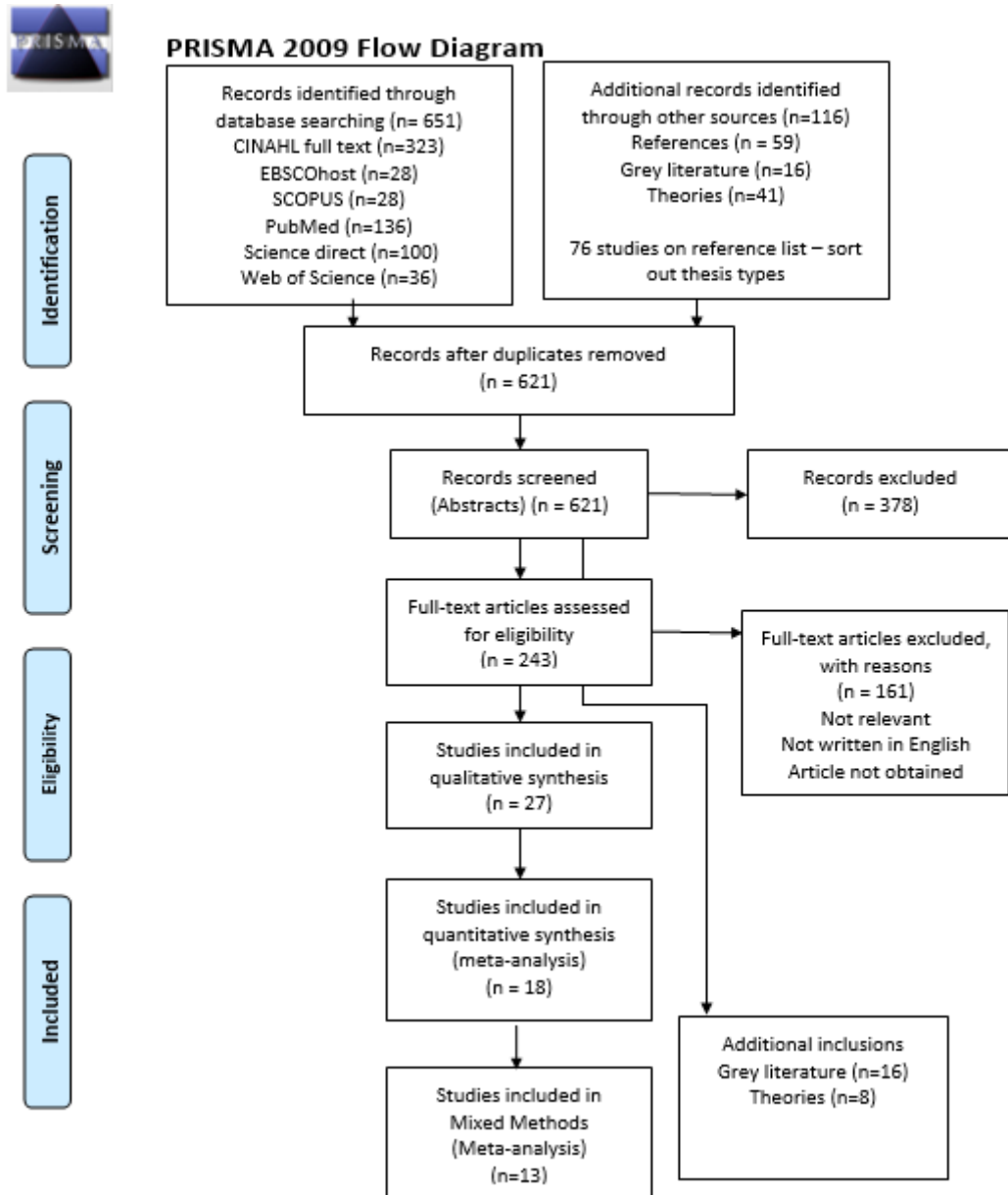


Figure 2: PRISMA flowchart for literature reviews

Additional records were also obtained from other sources; grey literature from professional organisations websites or nursing reports and searches for theories. The inclusion of grey literature was significant in providing context for existing gaps in the literature. To capture literature on theories, Academia Premier and Google Scholar were used for searches. The search terms were ‘theory’, ‘adult learning’, ‘systems theories’ and ‘clinical facilitation theories’. Further terms related to theories were then searched using terms as ‘Maslow’s’, ‘systems’, ‘facilitation’, ‘competency’, ‘learning’ and ‘risk theories’. Duplicates were removed from the total number of documents based on their title and relevance to the readiness of students. Document abstracts were

screened independently for content related to the search questions. The full texts were searched for eligibility. The literature on theory added to the total number of searched documents.

English-language literature was included if it had included any of the terms ‘facilitator’, ‘supervisor’ or ‘senior student’, or significant concepts related to nursing supervision and management. A scholarly paper by Deegan et al. (2007) was included as the authors raised concerns about issues with supervision and passing failing students. The review did not exclude global studies, but the focus was mainly on Australian studies.

Sources of literature were rejected on the basis of their title, the abstract or after reviewing the actual paper as they were not relevant, not written in English or was not able to be obtained. Secondary reviews such as systematic and integrated reviews were avoided as they were considered secondary interpretations (Bloomberg & Volpe, 2012). The search articles were recorded and reviewed, and key findings were documented using a template as suggested by Bloomberg and Volpe (2012). The capturing of data via this method proved useful for collating information for analysing its relevance and attaching meaning to concepts in the current study. The articles were read several times to build a solid understanding of the authors’ findings and conclusions.

2.3 Introduction to the Literature Review

Historically, the training of nurses in Australia occurred using an apprenticeship approach: students trained and worked in the hospital setting (DOH, 2013). However, the Sax report of 1978 identified that nurse training at the time was inadequate to cope with the diverging needs of healthcare and training of students (Tertiary Education Commission, 1978). The Sax committee reported that it was necessary to increase retention rates and to provide a more generalist approach to nursing training. The transition from hospital-based training to tertiary institutions began in 1974 and was complete by 1990 (Bessant, 1999).

Today’s nursing students receive a minimum of 3 years of formal education (DOH, 2013). Students must undertake a minimum of 800 hours of clinical practice to satisfy

curriculum requirements and demonstrate capability and competency in performing the *Registered Nurse Standards for Practice* (NMBA, 2016). The providers of education and healthcare settings work in collaboration to support students to become ready for the role of the RN. On the successful completion of student nurse education, students are deemed competent as beginning practitioners and can register with the AHPRA.

This review of the literature explored the current challenges and the theories related to the identification, assessment and management of readiness. The findings related to the current challenges to readiness are now reported.

2.4 Current Challenges to Readiness

This review of the literature describes the challenges that arise in the practice and attainment of readiness for the role of the RN. Aspects discussed include the identification, assessment and management of risk, which was associated with organisational and individual processes, practices and understanding about readiness. The four themes of the review are ‘providers and readiness’, ‘students and readiness’, ‘supervision and readiness’, ‘understanding readiness’ (see Figure 3).

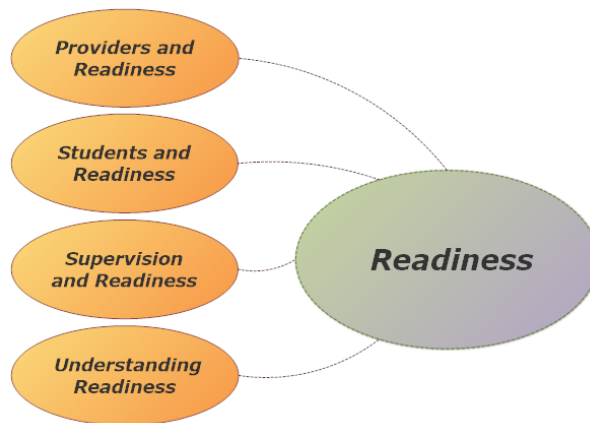


Figure 3: The review of current challenges to readiness

2.4.1 Providers and Readiness

The review of the literature showed that the infrastructure of HEPs and HSPs influenced the optimisation of the CLE (Department of Health & Human Services, 2016a). The assessment of nurse competency was influenced by the regulatory

standards as well as the assessors' understanding of these standards and the student assessment tools.

The framework to support clinical learning includes the themes 'best practice in clinical learning environments (BPCLEs)', 'current models', 'regulatory requirements', 'higher education providers and readiness', and 'health service providers and readiness'; each are described in Figure 4.

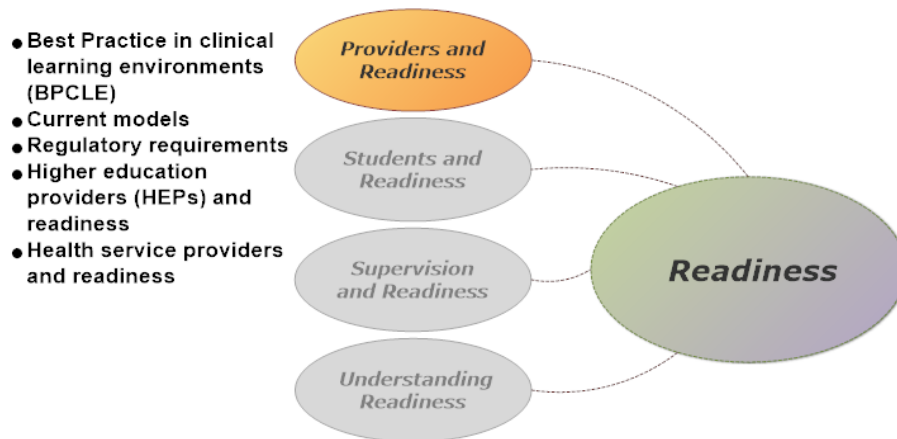


Figure 4: Current challenges to readiness—providers and readiness

2.4.1.1 Best Practice in Clinical Learning Environments (BPCLEs)

The BPCLEs occurred when students worked alongside skilled nurses who modelled behaviours of the professional nurse. Students had the opportunity to be responsible, accountable and independent in the delivery of care (Department of Health & Human Services, 2016a; 2016b). Six features describe BPCLEs in the Australian context: 'a positive learning environment', 'an organisational culture that values learning', 'effective communication processes', 'an effective health service–educator provider relationship', 'best practice clinical practice' and 'appropriate resources and facilities' (Department of Health & Human Services, 2009).

McAllister et al. (2018) in their New South Wales (NSW) study found an additional feature that their participants ($n = 23$) had ranked as the most critical: 'effective supervision'. However, supervisors considered that an organisational culture that valued learning and effective communications processes was more important than the quality of supervision. Least importance was the appropriate resources and facilities.

According to McAllister et al. (2018), the learning opportunities best tailored to student learning met the expectations for continuity between placement, student interests and their course requirements. Of concern, the Department of Health and Human Services (2016b) recognised that providing continuity between learning and placement was not always possible. McAllister et al. (2018) considered that challenges occurring in practice did not mean that the placement was of poor quality. However, as continuity and placement requirements do not deliver the features for continuity and curriculum requirements, learning appears compromised. Lockwood (2009) indicated that weak organisational systems, processes and relationships in the system negatively affect how staff critically think.

The Department of Health and Human Services (2016a) argued for the necessity to measure more than one indicator to identify the quality of support students had received. McAllister et al. (2018) endorsed utilising the perspectives of supervisors and site managers to inform and develop best practices in the quality of the placement. Although the Department of Health and Human Services (2016a) obtained views from a range of nursing professionals, the current study attempted to identify how CFs noticed those features that affected students on a final placement.

2.4.1.2 Current Models

The supervision of final-year nursing students occurs amid the competing demands of routines and expedient nursing care (Reid-Searl, Moxham, Walker & Happell, 2010). Current models that support nursing students provide the structure to place students (Birks, Bagley, et al., 2017) and ensure they receive supervision (Broadbent, Moxham, Sander, Walker, & Dwyer, 2014; Walker, Dwyer, Moxham, Broadbent, Sander, 2013) and learn about expectations (Brammer, 2008). Under these models, nurse supervisors guide student nursing behaviour (Gregory et al., 2008) and instruct students on how to provide patient care (Russell et al., 2010). The models assist providers and supervisors in understanding their role when assisting student learning. The current enquiry focussed on how these models address the needs with regard to support for students on a final placement—the placement models, supervision models and approaches to nursing care (see Figure 5).

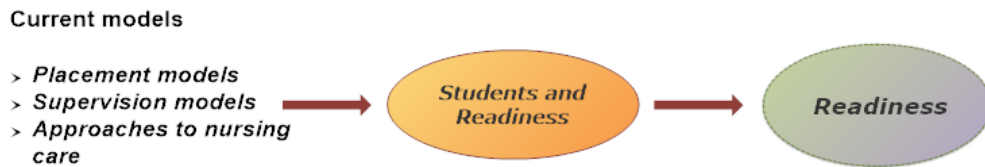


Figure 5: Providers and the use of current models

2.4.1.2.1 Placement Models

Placement models consist of a block (apprenticeship) style of placement or a distributed (flexi type) of placement (Birks, Bagley et al., 2017). The placement can occur during a semester or at the end. In most cases clinical practicums occur from Monday to Friday during the semester and students attend to other HEP and personal requirements outside this time (Nash, Lemcke, & Sacre, 2009; Patterson, Boyd, & Mnatzaganian, 2017). HEP requirements for students during block times include writing reflections on their clinical experiences and how these experiences matched the expected standards (NMBA, 2016). In WA the placements for students occur in a block placement outside the HEP teaching times. A distributed or flexi placement occurs over the entire academic year, during which students work two to three shifts each week and attend to HEP learning requirements outside this time (Birks, Bagley et al. 2017).

Birks, Bagley et al. (2017) explored third-year students' ($n = 22$) perceptions about the use of these types of placements. They concluded that block placements assisted final-year students to focus on specific learning for beginning practice, provided a realistic sense of work routines such as the giving of handovers, and enabled consistency in their supervisory relationships and early professional socialisation. However, the distributed model provided the time for study, employment demands and family responsibilities. The authors concluded that the model that was preferred depended on the individual needs of students (Birks, Bagley et al., 2017).

2.4.1.2.2 Supervision Models

A range of supervisors can be employed permanently or casually by the HEP or the HSP. Donnelly (2012) suggested that clinical teaching was the responsibility of either the staff from the HEP, the HSP or of both providers. The supervision models

reviewed in the literature were associated with the preceptor model, the facilitator model, the team model and the CEU.

In this review, the focus is on how students are supported by HSS such as the nurse with whom they work on each shift. Broadbent et al.'s (2014) study in NSW asked ward preceptors about the factors that affected their support for nursing students. These preceptors ($n = 34$) enjoyed having students on the ward, particularly when students knew what their role was. According to Broadbent et al. (2014), the preceptors derived both organisational and personal benefits from supervising students. However, similar to other research findings, the preceptors were not informed by HEPs that they had to supervise students. Consequently, they were underprepared to receive students (Brammer, 2008; Patterson et al., 2017). In combination with the demands of the workplace, supervisors felt conflicted about the supportive role they needed to provide to students (Broadbent et al., 2014). These authors did not clarify how HEPs were able to inform ward supervisors about the students they were supervising.

Brammer (2008) explored students' ($n = 24$) perceptions about the role performed by their buddy supervisors. Students saw the RN as the 'gatekeeper' who gave them access to learning opportunities and who would be aware of their needs and monitor and supervise their performance. However, students reported that buddy nurses did not always know what to expect from students and some buddy nurses had laissez-faire attitudes towards supervising students. A lack of supervision and continuity limits students' opportunities to see, do, and practice nursing in the way expected for developing confidence in the role of the professional nurse (Brammer, 2008; Zilembo, 2008).

According to Brammer (2008), while the RNs were the gatekeepers of practice, students had to strategise to obtain supervision. In some cases, students reminded the RNs that if not supervised they would fail the placement. It seemed that students were holding the supervising nurse accountable for their supervision and protecting themselves from failure. Spouse (2001) considered that support and limited opportunities to practice kept student learning in a 'cycle of deprivation' (p. 518). Brammer (2008) indicated that Australian regulatory bodies expected HEPs to be responsible for training preceptors about how to support students. The authors

concluded that not enough was known about informal encounters between RNs and their students in primary care settings.

Walker, Dwyer, et al. (2013) compared the facilitator role of supervising a group of students ($n = 159$) to that of the preceptor model. The most favoured model was that of the CF, which challenged student's reflection and thinking, and built on their existing skills, knowledge and ability to solve problems. However, the authors concluded that students learnt best when quality supervision and the promotion of student development had occurred.

In some studies, authors have found inherent weaknesses in the CF model. These weaknesses included having too many students to manage, the increases time required to assist struggling students (Black, 2011; Craven, 2015; Gregory et al., 2008), a lack of clinical expertise and experience (Needham, McMurray, & Shaban, 2016), having ineffective communication skills, being reluctant to fail students (Black, 2011), failing to report bullying and harassment concerns (Budden, Birks, Cant, Bagley, & Park, 2015) and not being able to assess a student's effective use of English. Nursing administrators considered students were at risk when CFs had limited experience, were difficult to source and did not remain in placement or had limited experience in the specialty areas in which they supervised (Gregory et al., 2008). The current study is likely to obtain more information about how facilitators deal with students in specialty areas in which they have little or no experience.

Gregory et al. (2008) reported that the casualisation of the workforce, the inexperience of the CF, increased patient acuity and lack of confidence and preparation in students all place pressure on the CF model. According to Gregory et al. (2008), this 'fault line' (p. 36) can fracture support for the CF model and increase the risk of unsafe patient care by students.

Russell et al. (2010) conducted an action research project to implement and evaluate a new team leader model of support. A student's team consisted of a new graduate and an experienced RN who acted as the supervising nurse for the shift. Students had the additional support of the CF and the ward liaison nurses who performed the role of the socialisation agent. As students were able to take a patient load and lead the decision-making process for patients, this model was found to prepare students for graduate

readiness, which concurred with literature related to providing opportunities for independence in the delivery of nursing care (Department of Health & Human Services, 2016a; 2016b). The team model of student support appeared to be successful; however, the response rate of participants was not known. Moreover, processes were not addressed for identifying, assessing and managing students who had struggled.

Both Lawrence (2014) and Nash et al. (2009) explored models that supported students from within specific educational units of a health setting. Lawrence (2014) utilised interviews and focus group meetings with third-year students in Victoria. Lawrence's (2014) study aimed to utilise and extend the model of the DEU to provide BPCLEs for student learning. The DEU model fostered a collaborative partnership where educational stakeholders were enabled to inform nursing practice. Lawrence (2014) utilised the services of both providers and students and called this model of supervision the Flexible Clinical Education model. In this model, the CI or CF held a dedicated position, and the CF was responsible for all communication, administration and educational needs. The HEP seconded the skilled CF. Resources provided on the ward consisted of information and working templates for preceptors to provide feedback, which CFs could access.

Lawrence's (2014) study achieved all the requirements for BPCLEs. However, once the preceptors had established a relationship with the student, a supportive health service–training provider relationship was established. This indicates that the model still relies on stakeholders getting to know one another. The current study attempts to explore how CFs value the relationships between supervisors, organisations, students and various models that support student learning.

Nash et al. (2009) identified that better outcomes resulted from collaboration, local ownership, positive learning environments, improved supervision arrangements and good outcomes for students and staff. They concluded that although they had utilised two different models for student support, there were no significant differences in the preparation of students. The findings indicated that the collaboration between the CF and HSS was significant on each shift a student worked. Students who sought challenging opportunities were seen to benefit from the newer model and had greater confidence. Although the study did not include external influences of organisations on

the students' development of competence, these findings support the concept that relationships were crucial for growing student confidence.

Although the RN is expected to supervise students on a final placement, the EN can also act as a supervisor. Ryan and McAllister (2017) developed a program to improve ENs' supervision skills. The ENs saw themselves primarily as clinicians with skills from which students could learn, but they experienced role conflict when expected to supervise an EN student studying to be a RN. Ryan and McAllister (2017) recommended that online resources and the sharing of experiences would guide them to develop solutions. The study was significant as it illustrates how ENs in Australia can take on the role of supporting and modelling nursing practice to undergraduate students.

However, according to the authors, preceptoring went across nursing divisions when ENs supervised Bachelor of Nursing (BN) students. Although the EN is considered the second tier of nurse and can be medication competent, students undertaking the BN in Australia must be supervised directly by an RN when giving medications (Haddad, 2016). The next section addresses how approaches to nursing care currently affect student readiness and the safety of patient care.

2.4.1.2.3 Approaches to Nursing Care

Nursing care approaches include the holistic nature of patient-centred care (Alderman, 2017). This approach explores the therapeutic needs of patients (Levett-Jones & Lathlean, 2009). Holistic nursing care also includes the patient's views of their needs (Alderman, 2017; Ferguson & Cioffi, 2011; Levett-Jones et al., 2017). However, this approach to nursing care is guided more by the placement than by the HEP. Significant models utilised to approach the delivery of nursing care are patient-centred care, specialty approaches to nursing care, the allocation of a small group of patients, team nursing, primary nursing and task assignment.

Alderman (2017) conducted focus groups and interviews with third-year students ($n = 179$) to explore the influence of clinical experience on the nursing students' understanding of patient-centred care. In her study, Alderman considered that student development was related to socialisation and the influence of experience; the importance of belonging and of being valued. The themes identified were:

‘conceptualising patient-centred care’, ‘the essentialness of leadership, team and culture’ and ‘meaningful work and being valued in the nursing team’.

Alderman (2017) found that the organisational structure or processes could affect the provision of holistic or total nursing care. Of concern, she described the relationship of students with staff and CFs as oppressive; where power imbalances prevented students from acquiring opportunities to learn. Further, she explained that holistic care did not occur in the team system as nurses talked more with each other than the patient. The process of giving bed-to-bed handovers did not invite patient participation. The use of audio recordings to verbally communicate nursing care given to patients meant that nurses had completed their shift and left the setting prior to handover. Thus, questions about care could not be clarified (Alderman, 2017).

Alderman (2017) found that specialty variations also influenced care; acute care settings focussed on illness, whereas mental health specialties focussed on patient-centred needs. Alderman (2017) advocated for nurse educators to empower students in this social context. However, these findings related to the views of students in one HEP setting and did not include the perspectives of other professionals. Alderman (2017) recommended that specialty areas be explored considering their social structures.

In the literature, there is an increased focus on specialty approaches (McInnes, Peters, Hardy, & Halcomb, 2015). McInnes et al. (2015) in NSW explored primary care placements as a final placement for pre-registration nursing students ($n = 45$). They identified these specialty nursing areas as general practices, schools, ambulatory care, community health centres, Aboriginal health and refugee health centres. Primary nursing included a focus on patient education through prevention and promotion and was different from the task focus of the acute settings (McInnes et al., 2015). Similar to McInnes et al. (2015), Coyne and Needham (2012) concluded that students in specialty areas needed customised learning objectives for the specialty area rather than HEPs’ prescriptive objectives.

Another model of nursing care is that of patient allocation where nurses are responsible for providing total care to a small group of patients. In NSW, Duffield et al. (2010) explored nurse staffing levels, experience and skill mixes to determine how they

influenced the choice of nursing care approaches. The authors identified that operational contingencies influenced the approach to nursing care. Models most frequently used in the medical, surgical areas were the patient allocation and the team approaches. However, the study was limited as it did not include how the delivery of nursing care occurred in other specialty settings. Duffield et al. (2010) concluded that no one model was prescriptive as the skill of staff, the circumstances of the ward and the need to make decisions would influence the choice of model used. In the above studies, it seems that both task and patient allocation models were considered beneficial to student learning.

2.4.1.3 Regulatory Requirements

The RN Standards for registered nurse practice can be referred to as the ‘gate’ to enter practice (Terry, Stirling, Bull, & Fassett, 2017). Nurse assessors act as the ‘gatekeepers’ of professional practice (Black, 2011; Brammer, 2008; Terry et al., 2017). They also actively seek to protect the profession and to protect patients from unsafe students (ALTC, 2014).

Terry et al. (2017) reported that RNs were experiencing tension in using the RN Standards developed by the NMBA (2006). Terry (2013) found that RNs did not have a shared understanding of competent practice for beginning or novice-level graduates. RNs did not connect the RN Standards’ elements to student practice and care. The authors concluded that the relevance of context to competence in practice was influenced by the contextual nature of the RN Standards, the disconnect between the function and the application of the RN Standards, and how students were introduced to the RN Standards. The understanding of the RN Standards also varied between nurses and graduate nurses and was inconsistently applied. The authors were concerned as regulatory authorities depend on all RNs, and on CFs to support and assess students against these RN Standards, to meet their professional expectations for accountability and assessment, and ensure that student practice remains safe. The authors recommended an urgent review of the RN Standards.

Cashin et al. (2017) also reviewed the RN Standards (NMBA, 2006) and compared them with those used in Canada, New Zealand (NZ), the United Kingdom (UK) and the United States of America (USA). The authors found these to be similar in

describing professional attributes and core areas. However, they identified that the term ‘fit to practice’ was commonly misunderstood by RNs as referring to the nurse’s health or lifestyle.

Cashin et al. (2017) developed and trialled seven new standards similar to international Standards, and indicated that nursing in the Australian context is converging on international consensus about nursing practices. These RN Standards (NMBA, 2016) were concise and responsive to the changing scopes of practice, role changes and models used by healthcare organisations and nurses (Cashin et al., 2017). The RN Standards (NMBA, 2016) were considered appropriate for the assessment of student competency and capability.

Levett-Jones et al. (2017) reviewed these new Standards and recognised that the new statements did not articulate how students or nurses were expected to meet key aspects of Standard 6, ‘to provide safe, appropriate and responsive quality nursing practice’ (NMBA, 2016, pp. 4–5). Patient safety was an overriding consideration (HWA, 2013; Tanicala et al., 2010) and students who provided safe nursing care would prevent errors and adverse events from occurring (Levett-Jones et al., 2017).

An outcome of Levett-Jones et al.’s (2017) study was the formalisation of nine competency statements in a Patient Safety Competency Framework from which nursing students could assess patient safety. These competency statements meant that patient safety included person-centred care, therapeutic communication, cultural competence, teamwork and collaborative practice, clinical reasoning, evidence-based practice, preventing, minimising and responding to adverse events, infection prevention and control and medication safety. Levett-Jones et al. (2017) expected that this evaluation would measure both knowledge and skills for safe nursing care observed in students. The next section identifies the added challenges associated with HEPs and the assessment tools they use.

2.4.1.4 Higher Educational Providers and Readiness

The current challenges associated with assessment tools and skill sets include problems encountered by HEPs. However, educational programs and assessment tools have been implemented to improve the quality of Australian supervision of nurses.

The literature findings discussed next relate to the assessment tools, skill sets and educational programs of the HEP (see Figure 6).

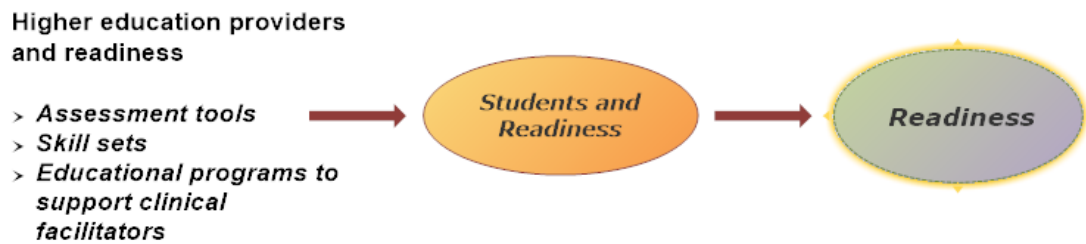


Figure 6: Higher education providers and readiness

2.4.1.4.1 Assessment Tools

The literature describes a concern with the use of assessment tools. This gives further credence to the discontent with current processes and the need to further support supervisors in the assessment of knowledge, skills, attitudes and behaviour of student competency. The assessment tools include formal and informal assessments for placements. Additional tools to conduct specific assessments will also aid in the identification, assessment and management of risk to student readiness and patient safety.

The majority of Western Australian universities utilise Bondy's (1983) modified criterion to assess nursing students (Brown & Crookes, 2017) as outlined in the *Nursing Competency Assessment Schedule* (NCAS). Brown and Crookes (2017) used a modified nominal group technique to explore how RNs ($n=87$) in Australia assessed student competency against the RN Standards (NMBA, 2006) with the NCAS as the evaluation tool provided by the HEP.

An outcome of Brown and Crookes's (2017) study was guidance notes developed and provided to assessors to include aspects of the 'work of the nurse'. The guidance notes recommended students be assessed through observations, questions and measurements such as writing and recording on documents and gathering information. The guidance notes assisted with the assessment of activities and nursing tasks. However, several studies reveal variation among educational assessment tools and grading criteria for meeting competency (Terry, 2013; Zasadny & Bull, 2015).

When using the NCAS, a student must demonstrate capability in autonomous practice (NMBA, 2016) at a beginning level, which is safe, competent, knowledgeable, with appropriate professional attitudes and essential clinical skills. This care is expected to be given independently of the supervising nurse (Brown & Crookes, 2016b). Every opportunity should be given to students to develop to an independent level (Department of Health & Human Services, 2016a). However, all assessments have a degree of subjectivity and the grading of students varies among educational institutions (Brown & Crookes, 2016b; Terry, 2013; Zasadny & Bull, 2015). In addition to the NCAS other assessment tools continue to emerge or are modified to include elements of Bondy's descriptors (Brown & Crookes, 2016b). Two such tools are the Australian Nursing Standards Assessment Tool (ANSAT) (ATLC, 2014), utilised in Victoria (Missen, McKenna, Beauchamp, & Larkins, 2016) and Queensland (Griffith University, 2014), and the Amalgamated Student Assessment in Practice (ASAP) tool utilised in Tasmania (Zasadny & Bull, 2015).

Students graded under the ANSAT can pass if they have been observed practising safely and sufficiently, with occasional prompting, supervision and guidance. Likewise, a final-semester student assessed using the ANSAT criterion (ALTC, 2014) must score a grade of 3, which indicates a satisfactory/passing standard. This may not equal proficiency but such students are deemed to be safe and requiring only occasional supportive cues. However, in Bondy's criteria (Bondy, 1983) a final-semester student is expected to attain a level where they are 'safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues' (Brown & Crookes, 2016b, p. 3). The difference is in the receipt of supportive cues.

The ASAP tool, developed by Zasadny and Bull (2015), was developed and trialled at the University of Tasmania to assess clinical reasoning. The ASAP functionality was to assess competency of student knowledge, skills, attitudes and behaviours using the three criterion grades of 'safe', 'effective' and 'proficient' (Zasadny & Bull, 2015). The assessment process utilised template tools to document feedback and a clinical learning contract (Zasadny & Bull, 2015). Although it appears that there is no criterion to fail students, the authors explain that the tool enables the remediation and/or removal of unsafe students (Zasadny & Bull, 2015).

Zasadny and Bull (2015) also identified how the tool assisted with students who were struggling as it had processes to use for remediation. Remediation occurred for specific areas such as having a deficit in knowledge, skills, attitudes, or behaviours for which students would receive a learning contract (Needham, 2014; Zasadny & Bull, 2015). Students were removed from the placement only if there was well-documented evidence that showed they did not meet the required standard for 'safe' care. The authors found student failure rates and successful student appeals had decreased.

San Miguel and Rogan (2015) developed a tool to assess the proficiency of the student with English as a second language (ESL). Students were graded against the descriptors of satisfactory (3), in need of development (2) or unsatisfactory (1). The tool assisted the CF to assess pronunciation and vocabulary; if students asked for clarification and if they could demonstrate they understood instructions. The authors found that with some assessors, students who had lived longer than 5 years in Australia were scored more harshly than more recent arrivals, while other assessors passed students on performance rather than language competency. Participants wanted more information on how to assist students.

San Miguel and Rogan (2015) identified that the tool needed further refining, but it was a beginning point from which further discussion and research could be conducted. They provided strategies related to the assessing of vocabulary, pronunciation, clarification and demonstration of understanding. Although the tool was only trialled in one state of Australia, it seemed significant for the assessment of English.

2.4.1.4.2 Skill Sets

The skills taught to students during their education are outlined in the curriculum, and each HEP is responsible for determining skills that students will need to master before going out onto a placement (Brown, Crookes, & Iverson, 2015); this is known as the students' scope of practice (Browning & Pront, 2015). These skills are both technical and non-technical and prepare students for undertaking the care of patients in a health setting placement and were identified in the work of nurses as clinician, communicator, manager/leader, researcher and educator (Brown et al., 2015).

The vast diversity of skill sets taught by HEPs is a source of conflict between students and HSPs (Haddad, 2016). Brown and Crookes (2016b) also questioned how some

specialty settings would be able to provide opportunities for practising these skills. Brown, Crookes and Iverson (2015) conducted an audit of skills in the curricula of Australian institutions and found there were 1,300 skills taught to students. These included aspects of communication, teamwork, leadership and supervision. Brown et al., (2015) declared there was insufficient time for HEPs to provide sufficient clinical opportunities to apply this range of skills during the student's placement.

Brown and Crookes (2016a) invited academics, clinicians, educators, directors and assistant directors of nursing ($n = 550$) to outline the essential skills from Brown and Crooke's (2015) list that a newly graduated RN should be able to perform. Experts came from aged care, mental health, community, primary and acute settings. The response rate was high ($n = 495$), which highlighted the importance of the topic. The researchers used a consensus approach to identify 30 clinical skills.

The top four nominated skill themes were efficient and effective communication, professional nursing behaviours, privacy and dignity and managing medication and IV administration. The lowest ranked were teaching/educator skills, acting as a resource or case manager, supervisory skills and leadership skills (Brown & Crookes, 2016a). Brown and Crookes (2016b) sought nurses' perceptions about the competency level in the skills for which new graduates should be independent (Bondy, 1983), which 'refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues' (Brown and Crookes (2016b, p. 3).

According to Brown and Crookes (2016b) 30 clinical skills were identified; just over half of the participants reported students could independently manage 18 of these skills. Two-thirds of the respondents thought students were independent and competent in the top four skills. The weakest area was students' ability to manage a case load of patients. The authors' findings indicated that students could only be skilled in some parts of providing care but not all parts. Brown and Crookes (2016b) advocated for connecting the skill set taught by the education provider and the development of competence in the clinical setting.

The primary limitation of Brown and Crookes's (2016b) study was that respondents reported on curriculum skills rather than what they thought were appropriate skills,

and they recommended that a range of skills in the clinical settings should be studied to prepare students for practice. However, these authors did not describe the effect of a broad range of organisational factors that may have influenced a student's competency. The current study aims to identify the assessment of skills as undertaken by CFs for students on a final placement and how skill sets taught are connected to and developed in the workplace.

Missen et al. (2016) conducted a study in Victoria examining the perceived quality of nursing graduates' competence. Competency was assessed using three ratings: poor/very poor, adequate and good/very good. Respondents (nurses, midwives and ENs) rated most new graduates' technical and non-technical clinical skills as adequate and very good for working as part of the team, working within their scope of practice, and utilising policy and guidelines.

However, new graduates could not critically think at the level that was needed, could not work independently or complete tasks in a prompt manner, or solve problems with patient assessments. Missen, McKenna and Beauchamp (2015) also found students appeared protected from taking responsibility for the whole of a patient's care. This finding appeared at odds with Brown and Crookes (2016b), who reported students as having the ability to assess, plan, implement and evaluate care. As Brown and Crookes's study was nationally conducted, this may provide a reason for the difference in findings.

An important finding in Missen et al.'s (2016) study was that some of the respondents were ENs and their inclusion to provide an assessment of the new graduates indicates that ENs may play a role in actively evaluating new graduate nurse performance. This contravenes Broadbent et al.'s (2014) expectation that assessors should be more highly qualified than the student undertaking their BN degree or of the new graduate. Of concern, Missen et al. (2015) had indicated that in the practices of ENs who had transitioned to the RN role, they completed tasks rather than led nursing care.

In contrast to this finding, Jacob, McKenna and D'Amore (2017) found that at times RNs and ENs did not see any difference between RNs' and ENs' ability to carry out nursing care. However, most respondents identified that although the EN's role had expanded, RNs had more leadership and responsibility, and would perform more

complex procedures. Further to this discourse, Ryan and McAllister (2017) identified that HEPs' systems allowed ENs to preceptor across nursing disciplines and indicated that this was an unsafe practice. How CFs accept or manage the student's ability to become ready and take on responsibility when supervised by the EN nurse has not been identified in this review.

In conclusion, students appeared sheltered from taking responsibility for the whole of a patient's care (Missen et al., 2015; 2016). Like the Department of Health and Human Services (2016a), these authors considered it necessary for students to experience more opportunities to be independent. Missen et al. (2015) recommended that a systems approach be used to address issues related to unreadiness. Further insight into how the CF works within and across systems and utilises education programs will enhance the understanding of how to develop students' responsibility and decision-making abilities.

2.4.1.4.3 Educational Programs to Support Clinical Facilitators

The training of HSS appears to be the responsibility of the HEP and HSP (NMBA, 2017); however, the HEP should monitor and support students by conducting assessments, providing support and giving feedback to both students and nursing supervisors (ATLC, 2014). The review of the literature reported next has identified that studies show how education programs could support supervisors and students.

Russell (2013) utilised a mixed methods exploration to design, implement and evaluate an education program entitled the Art of Clinical Supervision Program for Registered Nurses. The program addressed the seven core skills expected of all supervisors (HWA, 2010, p. 15): clinical skills and knowledge; adult teaching and learning skills; ability to give and receive feedback; communication; appraisal and assessment skills; remediation of poorly performing students; and interpersonal skills. Russell (2013) encouraged supervisors to implement the concept of belongingness to improve student support and promote a more positive workplace. Russell explored with participants Knowle's (1978) principles of adult learning theories and Bloom's Taxonomy of learning (Bloom, Engelhart, Furst, Hill, & Krathwohl, 1956) to provide meaningful learning and teaching experiences. Findings of the study demonstrated a

significant improvement in knowledge, skill and attitude towards supervision and students in general (Russell, 2013).

Mackay, Brown, Joyce-McCoach and Smith (2014) conducted a participatory action research study to identify the effect of including CFs in the planning of a professional development workshop. The supervisors requested academic support to relay difficult feedback to students. Following input from the CF, an education session then covered difficult feedback, adult education, the assessment of competency, familiarisation with the nursing program and the importance and use of student learning outcomes. According to Mackay et al. (2014) the inclusion of the CF in this partnership program had developed their leadership capacity.

Browning and Pront (2015) appeared concerned that HEPs did not provide an easily accessible framework to guide supervisors. The authors enlisted 28 CSs from four regional health settings to participate in a training package entitled the computer-based clinical supervisor educational package. Browning and Pront's (2015) training package offered four learning modules: defining roles, student feedback, skill progression and troubleshooting. The package provided content on adult learning as outlined by HWA (2010) and the WHO (2016). A five-point Likert scale was used to collect pre- and post-evaluations on the same day of learning. The authors concluded that the success of the education package was due to easy access to the study modules. However, they also concluded that the deficits in the program were related to an insufficient number of supporting documents and evidence for reflection and learning. Not included in their study were CFs. The current study will identify if CFs access training in WA. The next section outlines the challenges within health settings.

2.4.1.5 Health Service Providers and Readiness

Internal and external factors such as economic, political, human and other resources may adversely affect organisations trying to provide a BPCLE (Department of Health & Human Services, 2016a). These barriers can represent occupational stressors and create incivility in the workplace (HWA, 2012). The following studies are interpreted with caution because of factors such as a low response rate or the use of modified instruments. However, these studies are consistent with past data and emerging trends.

Three key themes identified were ‘the impact of belongingness’, ‘a lack of supervision and professional practice’ and ‘hostility in the workplace’ (see Figure 7).



Figure 7: Health service providers and readiness

2.4.1.5.1 The Impact of Belongingness

Levett-Jones and Lathlean (2008) explored third-year students’ experiences of belongingness in three HEP settings (NSW, Queensland and the UK). The authors found that without acceptance and inclusion, motivation changed from learning to working harder and students experienced greater anxiety (Levett-Jones & Lathlean, 2007). The authors concluded that consistent high-quality mentoring would ensure students felt connected to the workplace and would limit the risk to self-efficacy, self-concept, professional compliance and learning. Levett-Jones et al. (2009) considered experiences of belongingness essential for student learning and readiness. The students’ motivation to learn and be self-directed, their anxiety and their confidence to ask questions, were affected by factors such as the receptiveness of nursing staff, whether students were included or excluded in the clinical area and whether students were valued or seen as a nuisance. Students needed recognition and appreciation, and to be challenged and supported (Levett-Jones et al., 2009). A lack of belongingness would put the student at risk of not ascending to competency (Levett-Jones & Lathlean, 2008).

Doyle et al. (2017) measured the influence of pedagogical atmosphere, the leadership style of the ward manager and the assumptions of nursing staff and educators on the ward that would affect the students’ sense of belongingness. Two themes identified were ‘happy to help component’ and ‘happy to be here component’. According to Doyle et al. (2017), the ‘happy to help component’ revealed that the culture of the working environment was vital for students being comfortable and feeling as though they were included in the team.

Borrott, Day, Sedgwick and Levett-Jones (2016) examined the students' need to belong. They found students on a final practicum wanted guidance, opportunities to practice, acceptance and inclusion in the workplace. However, students did not need to have familiarity with a health setting or placement to progress. This conclusion seemed contrary to that of Birks, Bagley et al. (2017) and the Department of Health & Human Services (2016a), who concluded that a sense of familiarity would assist student learning.

The next section presents how a lack of supervision and professional practice are risks to competency and patient safety.

2.4.1.5.2 A lack of supervision and professional practice

The workplace culture provided a sense of belongingness and was defined as 'the attitudes, values, beliefs and social and behavioural norms held by the management, staff and physicians of the organisation, as well as the priorities established for work completion' (Lockwood, 2009, p. 10). Australian researchers explored medication practices of students. (Reid-Searl et al., 2009; Reid-Searl et al., 2010; Reid-Searl & Happell, 2011; Reid-Searl, Happell, Burke, & Gaskin, 2013) The practice and modelling of safe administration practices are significant to the role of the RN and are an important aspect when assessing readiness. Reid-Searl et al. (2009) explored experiences of final-year students ($n = 28$) when administering medication over several placement opportunities.

Reid-Searl et al. (2009) indicated that students felt caught between the expectations of the university and those of the RNs. This theory–practice gap meant that students felt they could easily be misled in their practices; they wanted to please staff and were worried about patient safety failing, or of not gaining expertise for registration. Poor modelling or unsafe practice is of great concern as all nurses are expected to model professional behaviour (NMBA, 2017). Reid-Searl et al.'s (2009) findings were limited to the students' viewpoints, but they highlight the need for CFs to manage for gaps in student supervision that could affect readiness.

In further research, Reid-Searl et al. (2010) studied 27 final-year nursing students and identified that they used behaviours of negotiating, chasing, waiting and avoiding staff when wanting to administer medication. If the response of the supervisor was one of

willingness, then students sought out supervision using the above behaviours of negotiating, chasing and waiting; if the response was negative, then students preferred to avoid staff and not give out medication. However, the effect of not giving out medication meant that while students remained safe, they were not developing experience. The other outcome of seeking out appropriate supervision was that a student could not promptly meet the requirements for 'providing safe, appropriate and responsive quality nursing practice' as medication delivery was delayed (NMBA, 2016, p. 2).

Reid-Searle and Happell (2011) conducted a study using two focus groups of RNs ($n = 13$) experienced in the acute specialties to determine their attitudes, experiences and opinions of supervising students to give medications. The findings showed that RNs considered it was essential to be responsible and accountable for directly supervising the safe administration of medication. However, RNs felt they did not receive communication about the student's scope of practice. They also were affected by the busyness of the clinical area, their attitudes towards students and how students acquiesced to the expectations of HSS (Reid-Searl & Happell, 2011). Similarly, Salamonson et al. (2015) reported that supervisors lacked time for supervision and knowledge about the students' scope of practice. Brammer (2008) also indicated that a lack of supervision occurred, which was related to the laissez-faire attitudes of staff, lack of awareness and poor vigilance.

Reid-Searle and Happell (2011) suggested that RNs should ask students for clarification about their scope for medication administration, and collaborate with the CF. The authors recognised that HSS and CFs needed to actively assess students. A limitation of Reid-Searle and Happell's (2011) study was that the CF was not part of the sample.

In a later study, Reid-Searl et al. (2013) again investigated the experiences of non-supervision in finally placed nursing students ($n = 35$). Students insisted on being directly supervised during the administration of medication. However, the authors concluded that adequate supervision of student nurses did not always occur and the lack of supervision was not a new finding (Budden et al., 2015; Ferguson & Cioffi, 2011; Zilembo, 2008). The authors still found that students feared that their grade for

practice would suffer if they did not do what the RNs asked of them. In Reid-Searl et al.'s (2013) study, the educator's voice was absent.

Reid-Searl et al. (2013) stated the 'onus is clearly on educators, healthcare organisations, and RNs to provide adequate support to students' (p. 113). The current review found that RNs and educators were not always supportive of students. Bullying and pressuring of students to work outside of the expected standards were other examples of poor practice (Birks et al., 2017).

2.4.1.5.3 Hostility in the Workplace

Unprofessional behaviour extends to incidents of hostility in the workplace. Included in this review is hostile behaviour as it affects students and hinders readiness. The CF must be able to manage issues related to student workplace aggression. The offenders can be academics, health setting nurses such as managers (Birks, Cant et al., 2017), healthcare assistants (Birks, Cant et al., 2017), nursing colleagues and patients (Hopkins, Featherstone & Morrison, 2014) and students (Birks, Cant et al., 2017; Budden et al., 2015; Hopkins et al., 2014). Aggression occurred through public humiliation, unjust or unfair treatment, sexual harassment (Birks, Budden, Biedermann, Park, & Chapman, 2018) and bullying practices (Birks, Budden et al., 2018; Budden et al., 2015). It was seen in behaviours that were physical or non-physical (Hopkins et al., 2014) through verbal, racial, sexual and physical abuse (Birks, Budden et al., 2018).

Of interest, Hanson and McAllister (2017) linked student vulnerability and disempowerment to not being aware of the realities of workplace cultures and practices. These authors advocated for the use of an emancipatory teaching model to develop skills of doing, being, realising, critiquing and visioning so students can reframe and reflect on the stressors. Student vulnerability and disempowerment will influence a student's ability to work confidently as a team member (Levett-Jones et al., 2009).

As students fear reprisal and are afraid of being denied employment opportunities, or do not believe remedial action will be taken, they do not report hostile or unwelcoming behaviours (Birks, Cant et al., 2017; Budden et al., 2015). What is of concern is how some students considered bullying was standard practice (Birks, Cant et al., 2017), did

not know where to report it or had considered the incidence of such behaviours was not sufficiently significant to report (Birks, Budden et al., 2017; Budden et al., 2015). However, Birks, Cant et al. (2017) indicated that under-reporting of violence would ensure that violence was perpetuated in the workplace.

The psychosocial influences of violence may have a long-term effect on the student's feeling of helplessness and the acceptance of bullying practices (Birks, Cant et al., 2017). The actions of violence by HSS towards individuals may adversely affect an individual's health (NMBA, 2017) and will also likely affect the student's ability to be ready for practice. Physical, verbal and sexual harassment of students can cause students to feel anxious (Birks, Budden et al., 2017; Birks, Cant et al., 2017) and lose their confidence (Birks, Budden et al., 2017; Budden et al., 2015) and self-esteem (Birks et al., 2017). These experiences may also limit their opportunity to learn, and compromise the quality of their clinical care (Budden et al., 2015).

Kealley's (2012) thesis outlined how new graduates' experiences of busyness, lack of competence, poor skill mix to provide them with support and being bullied or harassed had increased their stress levels. Bullying was a significant factor that caused beginning nurse's distress and withdrawal from graduate programs. Kealley (2012) recommended that appropriate training for supervisors and managers about how to manage and prevent workplace hostility would change the bullying culture in health settings.

Kealley (2012) also recognised that skill mixes did not necessarily support the beginning level nurse. Although the author reported that it was not a lack of knowledge but rather a lack of support that hindered new graduates, they concluded that undergraduate education did not prepare students for all aspects of nursing practice as students worked in areas outside of the skills they had practised or were not using the skills taught in the curriculum.

As aggression does occur in workplaces, scholars have suggested that students should also be prepared with knowledge of how to manage both verbal and physical assault (Budden et al., 2015; Hanson & McAllister, 2017; Hopkins et al., 2014). Preparing students for aggression might focus on coping rather than on changing the culture of the workplace.

The next sub-theme describes the attributes of students that either assist or hinder them in becoming ready for the role of the RN.

2.4.2 Students and Readiness

The theme of students and readiness deals with literature that identifies the traits of students that may support or hinder them in becoming ready for practice: work readiness, failure and CALD (see Figure 8). These traits will enable the CF to identify students who need additional support.

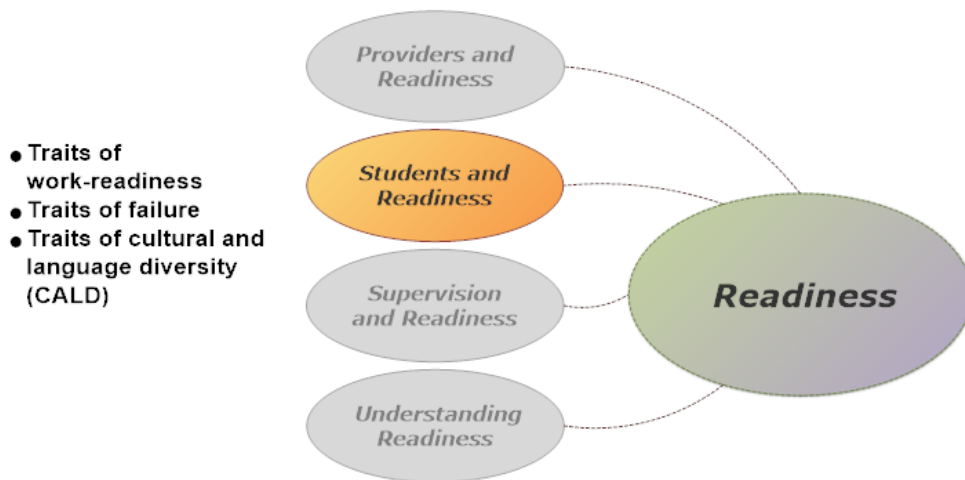


Figure 8: Students and readiness

2.4.2.1 Traits of Work Readiness

Walker et al. (2015) developed a survey for new graduates ($n = 450$) to validate a work-readiness scale. Their scale measured social intelligence, personal work characteristics, organisational acumen and work competence. Social intelligence aligned with the attributes of having useful communication skills, interpersonal skills, adaptability and ability to work in teams, and using collaboration. Personal work characteristics aligned with the attributes of self-awareness, adaptability, flexibility, personal skills and self-direction. Organisational acumen involved attributes of being socially responsible, having professional work ethic and self-direction, utilising lifelong learning and being motivated. Work competence aligned with the use of clinical skills, critical thinking and problem-solving abilities.

According to Walker et al. (2015), graduate work readiness was multidimensional and seen in students' skills, knowledge and attitudes. These characteristics were essential

for new graduates. In contrast to Haddad (2016), Walker et al. (2015) considered that when under pressure, confident students could cope and multitask better than those who were less confident. However, Walker et al.'s (2015) study utilised a modified instrument that needed further validation and the participants were graduates, not students.

2.4.2.2 Traits of Failure

Hunt et al.'s (2016a) study of mentors ($n = 8$), practice education facilitators ($n = 8$) and link lecturers ($n = 8$) recorded traits of failure in some struggling students. At times students utilised coercive and manipulative attributes to influence assessment. These traits were those of ingratators, diverters, disparagers and aggressors. Ingratators were charming and emotionally exploitive in their comments. Diverters distracted and redirected the teacher's focus from the issues at hand. Disparagers challenged or accused the mentor of undesired behaviour, and mentors felt intimidated and threatened by the prospect of being reported. Aggressors were openly hostile and made physical and non-physical threats towards mentors. These attributes increased feelings of guilt and fear to varying levels as the study subjects did not want to be reported by students, harm students or be unreasonable (Hunt et al., 2016a).

According to Hunt et al. (2016a; 2016b), mentors should recognise the locus of the failure, be able to use mentor preparation programs and access professional support services such as police and organisational debriefing structures. To manage these traits, the authors recommended that HEPs should manage how students perceived educators, mentors or their preceptors and ensure that students saw themselves as being on an equal footing with mentors. In the Australian setting, it might be difficult for RNs and students to be on an equal footing as preceptors are ultimately responsible for the delegation of patient care (NMBA, 2007) and retain authority over the students. As the coercive strategies of students are concerning, further information about how a CF identifies, assesses and manages the manipulative traits of students is warranted.

Tanicala et al. (2010) in Canada and the USA sought to identify what nurse educators considered was unsafe behaviour and would warrant failing the student. According to these authors the dominant theme was labelled as context and patterns. However, the patterns of safe or unsafe behaviour were transparent clarifiers of safety (Black, 2011;

Brammer, 2008; Terry et al., 2017), thinking (Skingley et al., 2007), ethics (Karlstrom, 2018), communication (Gregory et al., 2008) and the The RN Standards (Brown & Crookes, 2017; NMBA, 2006). Tanicala et al. (2010) considered that both educators and students were responsible for creating safe educational environments; thus, organisations needed to work together to remove a culture of blame. Although Tanicala et al.'s (2010) study lacked input from male nurse educators and educators from other cultures, the patterns and context of the above standards are not isolated findings.

2.4.2.3 Traits of Cultural and Language Diversity

Jeong et al. (2011) reported concerns that students who used ESL struggled in the workplace. In their NSW study they explored issues experienced by academics ($n = 4$), students with CALD backgrounds ($n = 11$) and CFs ($n = 3$). Similar to other findings, these themes were related to the level of English language competence, feelings of isolation, limited opportunities for learning (Alderman, 2017; Walker, Dwyer et al., 2013; Zilembo, 2008) and inadequate HEP support (McInnes et al., 2015). However, students with resilience were able to move onwards in the face of pressure (Jeong et al., 2011; Walker, Yong et al., 2013). The authors recommended that struggling students have continuity of supervisor, which would make it easier for students to communicate with their supervisor (Jeong et al., 2011).

CALD aspects were also explored by USA authors Sherman and Eggenberger (2008), who focussed on the recruitment of international nurses to nursing settings. These findings are worthy of consideration as CFs must also assess students who are working to obtain an Australian registration. These nurses may bring with them ways of nursing that will influence their learning patterns. Sherman and Eggenberger (2008) found that different cultures practice nursing with different approaches. They identified that decision making, nursing practices and beliefs influenced how care could vary internationally. They concluded that overseas nurses required knowledge of aspects of medication, communication and assessment skills and needed to answer patient questions as part of their orientation. Although this study was limited to the American context, the findings are significant in regard to further exploring how CFs in WA can factor in risk factors for students with CALD.

Edgecombe et al. (2013) reviewed issues that international nursing students experienced in CLEs. Similar to other findings, students felt themselves the outsider, isolated and discriminated against, and struggled with communication, financial and family issues (Craven, 2015; Edgecombe et al., 2013). Communication barriers were related to CALD (Craven, 2015), culture shock and a lack of authentic relationships of nurses with students (Craven, 2015). International students desired to be accepted and valued (Edgecombe et al., 2013; Levett-Jones & Lathlean, 2007) and Edgecombe et al. (2013) recommended the use of strategies to minimise threats to international nurses.

Of interest, Deegan et al. (2007) identified that international students had been given recognition for prior learning and were not required to undertake basic science and human bioscience. The authors recommended that organisations raise awareness about these challenges, provide additional support to a student from a non-English-speaking background (NESB) and improve the culture of the workplace. Deegan et al. (2007) reported students on this pathway were unable to link theory to practice. There appeared to be a gap in knowledge about how CFs managed the diverse backgrounds of students and educational pathways. Deegan and Simkin (2010) recommended further exploration of the challenges associated with students from a NESB.

The next part of the review describes the literature related to supervision.

2.4.3 Supervision and Readiness

CFs and CSs are essential for providing the best environment for student learning and competency (Department of Health & Human Services, 2016a; McAllister et al., 2018). This review discusses findings relating to BPCF. However, often the CF's role is interchanged with the role of the CS (preceptor, buddy nurse, mentor). This next theme reports on the two themes associated with current literature about the supervisory role: 'best practice in clinical facilitation' and 'managing risk' (see Figure 9).

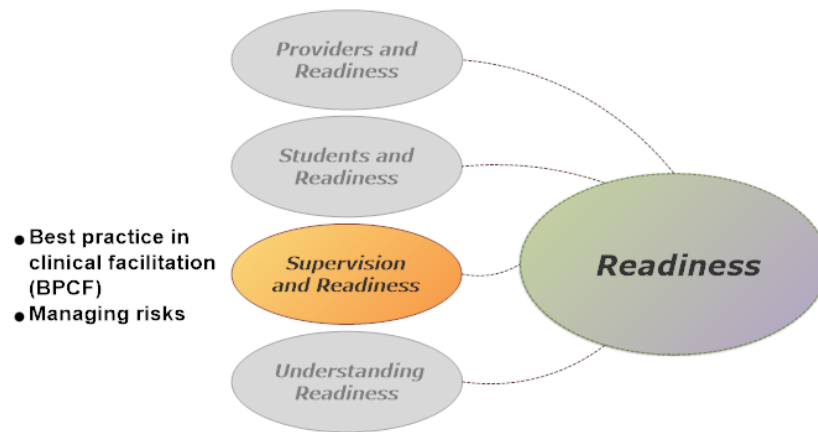


Figure 9: Supervision and readiness

2.4.3.1 Best Practice in Clinical Facilitation

Needham et al. (2016) used the perspectives provided from CFs ($n = 11$) to develop a BPCF model for Australian facilitators, which included three aspects: assessing, learning to facilitate and facilitating effectively. Assessing students involved identifying needs that were general, specific and in a context where learning matched specific learning and placement needs (McAllister et al., 2014; Needham, 2014). The authors recommended that facilitators require formal preparation and knowledge about formal and informal assessments (Needham, 2014; Terry et al., 2017) and should maintain their knowledge, develop networks and model professional behaviour (Needham, 2014). A high level of communication skills was also needed to facilitate effectively (Needham, 2014).

However, Needham et al. (2014) found that CFs felt professionally isolated, lacked educational foundations and did not always know the policies and guidelines of HEPs and HSPs (Needham et al., 2014). According to Needham (2014), CFs also struggled to manage professional accountability to both providers and felt separated from or outside both the HEP and HSP organisations. Needham (2014) recommended it was essential to develop BPCF by inviting the CF to formally and informally share their experiences with other colleagues and academics.

The CF's function was seen to bridge between organisations (Needham, 2014). Bridging or straddling is a connection between two points or, in clinical facilitation, having a 'foot in both camps' from which individuals attempt to meet the expectations of differing organisations; to optimise learning and reduce risk. In nursing terms,

understanding how the CF can optimise their ability to I, A & M risk when working across two organisations will provide further insight into the role of dealing with risks associated with organisations and their expectations.

HWA (2010) has identified six core skills or competencies for the supervisors and facilitators of nursing students. These core competencies enable evaluation of cognitive (knowledge), affective (attitude and behaviour) and psychomotor (skills and ability) domains of learning and teaching (WHO, 2016). However, the WHO (2016) recognised that for nurse educators a global consensus had not been obtained.

The WHO (2016) captured more components suggested in the literature than the 2010 study by HWA. The WHO core skills include additional skills related to research, ethics, management, leadership and advocacy. These skills provide a range of competencies that CFs are expected to perform effectively to support students; see Table 1 for the core competencies required for BPCF.

Table 1: The core skills of facilitation (WHO, 2016)

HWA, 2010, p. 10	WHO, 2016
Clinical skills and knowledge	Competency 1: Theories and principles of adult learning
Adult teaching and learning skills	Competency 2: Curriculum and its implementation
Ability to give and receive feedback	Competency 3: Nursing practice
Communication, appraisal and assessment skills	Competency 4: Research and evidence
Remediation of poorly performing students	Competency 5: Communication, collaboration and partnership skills
Interpersonal skills	Competency 6: Ethical/legal principles and professionalism

These core competencies help to bridge the gap between theory and practice and manage risk to ensure the safety of all individuals (HWA, 2010). The core skills can be assessed nationally, by an organisation or by self-evaluation (WHO, 2016). The next section of the review discusses the management of risk.

2.4.3.2 *Managing Risk*

Patient safety is recognised as the foremost concern, above that of student education (HWA, 2013b; Levett-Jones et al., 2017). This section of the review describes how various authors have identified, assessed and managed underperforming, borderline or unsafe nursing practice of students. These studies include aspects of the ‘factors influencing assessment processes’, ‘identifying and assessing risks’ and ‘managing risk and failure’.

2.4.3.2.1 Factors Influencing the Assessment Process

Terry (2013) in Tasmania utilised a critical realist perspective to understand how individual or collective agency and organisational structures had influenced the assessment of students. This is significant as the student who passes but is not ready is likely to place individuals at risk of unsafe practice. The assessment of competency was influenced by the relational aspects of the assessor, the assessed and the context of the environment. Supervisor training on how to assess nursing students was not always provided (Needham, 2014; Terry, 2013) and decisions were based on the assessor’s skill of interpretation and practical wisdom (Terry, 2013). As such, tensions existed between nurses about the RN Standards (NMBA, 2006) and the assessment of competency.

Terry (2013) stated that at the individual level nurses have the power to adapt and make changes. However, the ability to make changes will be guided by organisational structures and the Standards that guide the supervision and assessment process. The CFs and CSs are also expected to evaluate the outcomes of their supervisory experience to better inform nursing practice (NMBA, 2016).

Gregory et al. (2008) focussed on patient safety and saw the need to protect patients from errors and adverse events occurring from education and practice systems. A random sample of 60 learning contracts was sourced to identify issues experienced by students. To identify issues, the authors utilised focus groups and interviews with a wide range of professionals and nursing students ($n = 40$): clinical nurses (CNs), educational administrators, staff nurses and unit managers, and risk management officers. The sections of the learning contracts consisted of ‘professional/socialisation

issues', 'nursing care concerns', 'clinical transgressions', 'remediation and/or rehabilitation', 'clinical expectations' and 'evaluated outcomes'.

The focus group interviews identified factors of risk to patient safety as the CF model, the concerns about students, the students lack of preparation for practice and the nursing program. Similar issues surrounding nursing relationships, systems and processes have been reported in Australian studies (Levett-Jones et al., 2017; Terry, 2013). Issues that had an effect on patient safety were related to a high turnover in course leaders, training using the controlled laboratory environment for practice rather than busy environments, the inadequate development of concepts related to patient safety, limited opportunities for student practicums, lengthy delays between learning skills and practice, and short placements (Gregory et al., 2008;. Levett-Jones, Lathlean, Higgins, & McMillan, 2008). In addition, if HSS was not supportive of students a culture of blame had arisen.

According to Gregory et al. (2008), risks to patient safety were also identified by the concerns of the CFs, health service settings and students. CFs were concerned about patient safety, students obtaining consent, ensuring the environment was safe, providing emotional and spiritual care to students, maintaining students providing care, and providing safety to patients. HSS reported there was limited communication about curriculum expectations of HSS, and day-to-day data on student incidents were buried within the clinical system. Gregory et al. (2008) reported that students who were unsuccessful in passing the requirements were found to have lacked professional attitudes, had inadequate and ineffective communication skills, were not able to organise nursing care, did not demonstrate critical thinking, did not administer medication safely and had inadequate knowledge, assessment, recording and reporting skills.

The unsafe practice of students was also reported on by Karlstrom (2018). She ranked responses about unsafe practices from expert CN educators ($n = 17$) who considered that behavioural 'deal breakers' were those ranked as dishonest behaviours, unsafe or limited knowledge and unsafe practice. She reported that nurse educators expected students' practice and personal life to be one of scrupulousness and precision. Expectations for students' behaviour were based on moral integrity, practising according to the RN Standards and being honest.

To ensure students' practice was safe; the CFs remained in tight control over their learning activities. However, nursing educators were outsiders to the health setting and were often not familiar with system requirements and routines. Karlstrom (2018) advocated for CFs to model the behaviour expected from the Standards and support the student's scope of practice. The study was not generalisable to all supervisors, but extended understanding about the hierarchy of unsafe behaviours. The current study will clarify how CFs remain in control over the identification, assessment and managing of risk to readiness on a final placement.

2.4.3.2.2 Identifying and Assessing Risks

The following studies reported on how struggling students were identified and assessed in Australia by RNs, nurse graduates, educators, graduate nurses and managers (Brown & Crookes, 2017) and mentors in the UK (Cassidy, Coffey & Murphy, 2017; Duffy, 2013). Brown and Crookes (2017) utilised a modified nominal group technique in Australia to explore how experienced nurses and nurse graduates ($n = 87$) undertook assessments. Assessments were made through 'observations', 'questions' and 'measurements' of behaviours against the Australian standards (NMBA, 2006). RNs wanted to assess capability, quality and safety, appropriateness, timeliness and students' values in therapeutic relationships.

Assessors valued observing communication and nursing care skills. Communication skills were indicated by the student's ability to work within a team, which effectively engaged with others, communicated and used teaching strategies to support patients (Brown & Crookes, 2017). Assessors also valued efficient nursing care skills of good time management, prioritising of care, recognising deteriorating patients, utilising policies and other information, completing care requirements and understanding about scope and skill mix.

Cassidy et al. (2017) set out to explore mentors' ($n = 20$) assessments of borderline competency in students. Focus groups were utilised ($n = 11$) to build on these findings. The authors recognised that conflicts, disputes and feelings of inadequacy occur about the assessments made by mentors and the roles that they perform. Four themes identified were 'the conundrum of practice competence', 'the intensity of nurturing hopefulness', 'managing assessment impasse' and 'seeking authorisation: establishing

collective accountability for mentorship'. According to Cassidy et al. (2017), assessments were often up to the assessor's interpretation as they did not utilise pre-defined competency statements (Cassidy et al., 2017).

However, in Terry et al.'s (2017) study, although pre-defined competency standards were used, assessors would still interpret the RN Standards differently. These findings illustrate how the assessment process is subject to an individual's perspective (Amicucci, 2012; San Miguel & Rogan, 2015). Cassidy et al. (2017) identified that mentors perceived that the assessment process would not be compromised if they nurtured hopefulness for student progress. However, assessors often omitted assessing for the skills, behaviours and attitudes expected for professional competence; particularly when influenced by a student's positive or negative characteristics (Cassidy et al., 2017).

Cassidy et al. (2017) described the process of using information from others and from previous placement experiences of students to establish collective accountability for mentorship. Although mentors (practice educators and health setting nurses) sought colleagues' advice, they did not always feel connected to other mentors. At the time of the study new standards had been introduced and significant restructuring was occurring in the UK. This gives cause for being cautious about the results. Cassidy et al. (2017) recommended the personal, professional and organisational preparation of mentors be provided for the management of borderline students.

2.4.3.2.3 Managing Risk and Failure

Managing risk and failure appeared to occur in steps or stages (Craven, 2015; Duffy, 2013; Skingley et al., 2007). Gregory et al. (2008) focussed on the learning contract and patient safety. Hunt et al. (2016b) focussed on how CIs decided to fail students.

Duffy (2013) identified that in Scotland there were three actions or steps that mentors used to manage a failing assessment. First, they identified weak students through recognising early signs, making informal approaches and seeking support with making the assessment. Second, they created possibilities for success through developing an action plan where the student, the mentor and practice teacher worked closely with students, provided students with daily feedback and ensured that students perceived they had been fairly treated. The third step was to decide to fail students. This step was

found to be emotionally challenging. Mentors experienced self-doubt and felt uncomfortable and somewhat personally responsible for students failing (Duffy, 2013).

Failing students had demonstrated behaviours that were intimidating, angry or manipulative towards nurse professionals, and had lacked awareness about their progression (Duffy, 2013; Gregory et al., 2008; Hunt et al., 2016a; Skingley et al., 2007). Mentors wanted feedback from academia about how they had provided for and managed student failure. The current study attempts to identify how the CF manages the struggling student in the context of the factors that hinder the student's progress.

Craven (2015) explored strategies used by Canadian academic CFs ($n = 28$) to I, A & M struggling students. Three significant actions performed specifically to notice red flags of underperformance were: 'being present', 'setting a new course' and being objective'. Although Craven's (2015) study was conducted in Canada, it provides a useful framework that educators might use to manage failing students. Craven (2015) recommended development of further strategies to manage underperforming students. As Craven (2015) did not explicitly situate the student on a final placement and did not identify the barriers that had influenced assessors in managing failing students, the current study aims to fill these gaps.

Skingley et al. (2007) also emphasised the essential actions or guidelines that their practice teachers ($n = 34$) in the UK could use when students failed to progress. To manage for these factors, the practice teacher utilised their 'intuitive judgement'. The bottom line for practising teachers was the need for 'safe practice'. The authors recommended that HEP and practice teachers should collaborate to produce guidelines to recognise signs of failure and how failing students should be managed.

Gregory et al. (2008) reported that the CFs directed students throughout their placement to protect students from making errors, and debriefed students about what went well and what did not go well. According to Gregory et al. (2008), students in their final practicum were expected to write reflections and manage a caseload of four patients, demonstrate critical thinking, utilise effective communication and have more contact with their supervisors than traditionally provided. The preceptor was expected to liaise with the student on each shift and the CF with the students at designated

periods near the end of the placement period. The authors reported that these practices enabled mutual accountability.

In Gregory et al.'s (2008) study, they reported that students were directed to learn more about their deficiencies in areas such as the development of skills, knowledge and fitness to practice. To develop skills, students could go to the laboratory to practice with clinical scenarios before going back into a placement. The development of knowledge included the review of policies, procedures, texts and library resources to improve the ability to undertake a skill.

Gregory et al. (2008) said failure was identified mostly at the end of the placement. When students were identified as struggling, Gregory et al. (2008) indicated, learning contracts were given to students to improve and monitor their progress. Students were directed to learn and practice to manage personal issues, reflect on practice, care for up to four patients, demonstrate critical thinking and develop more effective communication skills. Issues experienced with the plan were related to students feeling threatened, the fact that the plan was a requirement, was often used as a last resort and was a challenge to implement promptly (Gregory et al., 2008).

These authors indicated that learning contracts should be positively implemented, be clear and be concise. The CI should have a copy and issues should be discussed thoroughly with students. Unsafe students could be removed from the placement area with documented evidence for the reason (Gregory et al., 2008; Zasadny & Bull, 2015). Gregory et al. (2008) concluded that more information about how HSS are utilised in the monitoring and management of a failing student was needed. The current study aims to fill this gap.

Similar to these researchers, others also identified that failed students continued to lack professional attitudes, communication skills (Craven, 2015), knowledge and critical thinking (Zasadny & Bull, 2015) and were unable to organise nursing care. Although this study was undertaken in a Canadian context, it adds to global knowledge about failing students. More information about how HSS are utilised in the monitoring and management of a failing student was seen to be needed.

Hunt et al. (2016b) conducted a study in the USA to explore practice teachers' perceptions about what enabled them to decide to fail students. The participants

($n = 31$) were mentors, link lecturers (HEP lecturers) and practice education facilitators (employed in the health setting and with similar responsibilities to the link lecturer). Three areas focussed on were referrals, the subsequent passing and failing of students and their withdrawal from the placement (Zasadny & Bull, 2015).

Hunt et al. (2016b) further identified four needs of mentors: emotional support; appraisal support such as feedback and affirmation; instrumental support such as time and resources; and informational support that would guide the supervisor to navigate decision making. These authors recommended further research in areas of the ‘gist’ of underperformance, appeals and failing students. In the current study, the identification, assessment and management of underperformance is explored. The next findings from the literature relate to how readiness was understood.

2.4.4 Understanding Readiness

A beginning-level standard for a new graduate is to manage a variety of patients with non-complex needs (ALTC, 2014). The actions to solve these are to identify problems, determine steps to take, prioritise appropriate actions, be aware of personal limitations and seek support within a reasonable time frame (ALTC, 2014). To demonstrate competency and readiness, students must demonstrate care according to the NMBA standards (NMBA, 2016). This theme is the final theme of the review of the literature. Figure 10 illustrates where the theme of ‘understanding readiness’ is situated.

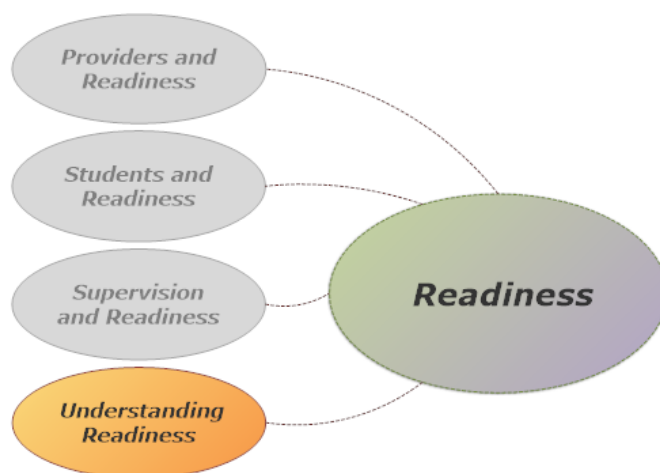


Figure 10: Understanding readiness

HEP curricula require students to be graded using Bondy’s competency scale (Bondy, 1983) or a modified Bondy’s scale. However, there is little consensus among nursing

professionals about what it means to be ready for practice, ‘work ready’ (Haddad, 2016; Walker et al., 2015) or to ‘hit the ground running’ (Levett-Jones, 2007; Nash, 2007; Woods, et al., 2015). Various authors reported differing expectations, from being competent and independent without supportive cues, to practising safely with supportive cues (ATLC, 2014; Zasadny & Bull, 2015). These disparities seem to indicate varying expectations about new graduate nurse readiness and competency.

Woods et al. (2015) recognised that although apprenticeship-type training had been replaced with higher educational training, students were still underprepared. Health setting factors had influenced the training, support and socialisation of undergraduates (Missen et al., 2015; Needham et al., 2016). To understand these factors, Woods et al. (2015) in Queensland explored the confidence level of students after they had completed a capstone unit. A capstone unit was expected to consolidate learning and prepare students for professional practice and nursing registration (Department of Health & Human Services, 2005). Activities such as lectures, tutorials and clinical practice would extend how students critically reflected and practised (Woods et al., 2015).

The capstone project implemented by Woods et al. (2015) included a process of attending lectures, followed by simulation and discussion to improve students’ clinical reasoning and work readiness. The assessment of student readiness was made using the Casey–Fink Readiness for Practice Survey tool. This adapted tool measured students’ confidence to manage five acute episodes of care: care with an insulin transfusion, haemodynamic instability, potential airway threat, a respiratory event and physical trauma.

According to Woods et al. (2015), students were confident in their professional identity, ethical practice and using the systems of care such as the documenting of patient care and asking for assistance. They felt they had opportunities to do procedures and develop skills more than once and felt ready for the role of prioritising patient care needs, solving problems and recognising deteriorating patients (Woods et al., 2015). The authors found students were least confident in independently performing skills that were more specialised, such as venepuncture, intubation and insertion of a Guedel airway.

Healthcare experiences of students have previously been linked to an increase in confidence in providing nursing care (Birks, Bagley et al., 2017; Woods et al., 2015). Woods et al. (2015) found that 75% of their students had worked previously in healthcare. They found that younger students had higher levels of confidence to manage multiple patients. However, the authors concluded that a student's confidence in completing tasks with limited practical experiences did not mean that they would competently provide care.

Wolff et al. (2010) conducted focus groups in Canada ($n = 15$) to identify what nurses ($n = 150$) considered was meant by 'graduate readiness'. According to the authors, readiness included having the ability to keep up with current realities and future possibilities by accessing resources and using tools. The final assessment of readiness was based on balancing their actions of doing, knowing and thinking where they were academically prepared, having undertaken the practice component of learning and placed their learning and practice in the context of the setting in which they practice (Wolff et al., 2010).

These authors saw a disconnect between expectations for readiness. Their thinking had shifted from 'ready to hit the ground running' to global readiness, with competencies that were at an entry level and that were specific to the job or the performance of skills. Readiness meant that patients could receive safe care and that new graduates would be able to adapt to organisational changes and general needs for specific healthcare (Wolff et al., 2010). The authors advocated that terms such as readiness and job readiness not be used. Instead, a shared concept of readiness to practice should be adopted.

Wolff et al. (2010) considered that a common understanding of readiness would minimise division between nursing providers and individuals. For the current study readiness for practice means that student nurses have a readiness to practice when they have successfully demonstrated they can provide safe and competent nursing care at a graduate level as set out by the Standards for Australian RNs. The current Standards are as follows: thinks critically and analyses nursing practice; engages in therapeutic and professional relationships; maintains the capability for practice; comprehensively conducts assessments; develops a plan for nursing practice; provides safe, appropriate

and responsible quality nursing practice; and evaluates outcomes to inform nursing practice. Other terms similarly used are work readiness and fit to practice.

Haddad (2016) interviewed BN placement coordinators (BNPCs) ($n = 9$) and nurse unit managers (NUMs) ($n = 7$) on their perceptions of how ready new graduates should be for practice. In exploring the term 'student readiness', Haddad (2016) found a mismatch between BNPCs' and NUMs' expectations. BNPCs expected the new graduands to 'hit the ground running' as they would need to manage a group of patients and would need to cope with a stressful workplace. In contrast, NUMS expected new graduands were not work ready upon employment, but were on a journey of developing competence that would require time.

According to Haddad (2016), this finding indicated that there was a disparity between the providers about the readiness of students on the completion of their tertiary training and practice. Haddad (2016) found that student readiness can be determined only as general readiness, rather than being ready for all specialties. The training was influenced by contextual issues such as systems, enculturation and the expectation of new graduands to be able to 'hit the floor running' (Haddad, 2016, p. 175).

Christensen et al. (2016) examined the extent to which students ($n = 223$) on final placement in Australia, the UK and NZ felt insecure and doubted their ability to handle the responsibility of the RN role. The authors utilised the Clance Imposter Phenomenon Scale, which measures feelings related to the fear of evaluation and not being successful or as capable as others. The second tool used was the Preparedness for Hospital Placement Questionnaire for Nursing, which similarly uses a five-point Likert scale to measure student confidence and preparedness to manage clinical situations and apply their knowledge. Students in the UK had to complete 2,300 hours of training; NZ students, 1,300 hours; and Australian students, 800 hours. The study found that the additional hours did not contribute to the preparedness of students. Of interest, the Australian and UK cohorts scored lower than the NZ students for feeling like an imposter. The authors concluded this was related to the apprenticeship style of training NZ students had received.

The literature review in this thesis has outlined the enablers or barriers that either support or hinder the student's ability to become prepared and the CF's ability to

support students. The areas identified were associated with the HEPs and the HSPs, the students and the model of supervision. Moreover, the literature described the attributes of being ready for the role of the RN. The next section sets out the theories that are relevant to the phenomenon under study.

2.5 Theories Explaining Readiness

The theories employed in this study will need to provide an explanation for or description of the ways inexperienced and experienced CFs can manage risk to a student's competency and readiness on a final placement. Two questions asked are, 'What concepts were related to the phenomenon?' and 'What theories would support the interrelationships among the concepts?'. The theories selected in Figure 11 were based on relevance to the phenomenon: General Systems Theory, Facilitation Theory, Bloom's Taxonomy, Approaches to Risk and the Ascent to Competence.

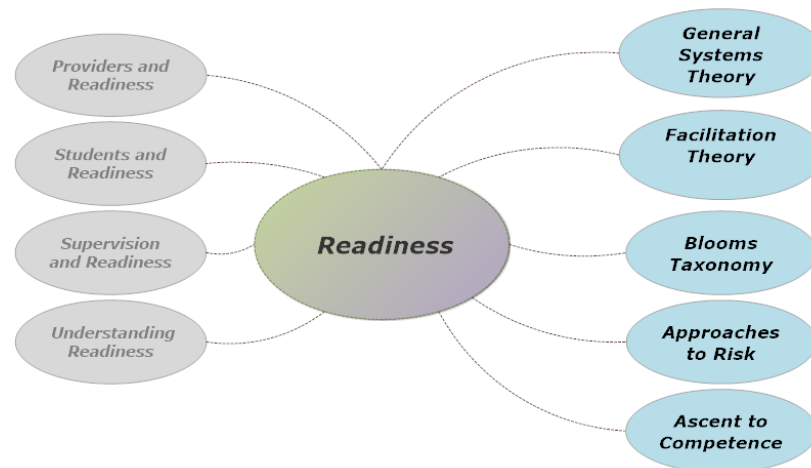


Figure 11: Theories explaining readiness

2.5.1 General Systems Theory

The systems category of knowledge focusses on maximising the operations of systems and can be used to understand behaviour. The nature of General Systems Theory is one of interaction between the parts of the system and the external environment (Von Bertalanffy, 1968). The system can be closed or open to external environments and can describe the relationships among components. The benefit of the General Systems Theory is that it can be used in complex settings where variables are examined, to identify the relationships among variables and make predictions about the system (Ramosaj & Berisha, 2014).

The system components are inputs, outputs (Harcourt & Cornell, 2015; Von Bertalanffy, 1968), throughputs and feedback (Ramosaj & Berisha, 2014), as well as the boundaries of a system (Harcourt & Cornell, 2015; Kast & Rosenzweig, 1972). The General Systems Theory can explain how entropy occurs (Von Bertalanffy, 1968). Burke and Litwin (1992) described how systems can explain the connections between parts or sections of the system.

The Open Systems Model was chosen for this study as it is seen as essential for understanding social organisations (Kast & Rosenzweig, 1972) and their effect on the development of learning. The systems approach can be used to describe how the CF can facilitate learning and development from the inputs received within the structures provided by educational providers and HSPs as both students and facilitators are reliant on specific components of the system. These parts of the system are now briefly described. Katz and Kahn's (1978) Open Systems Model as reported by Ramosaj and Berisha (2014, p. 61) is depicted in Figure 12.

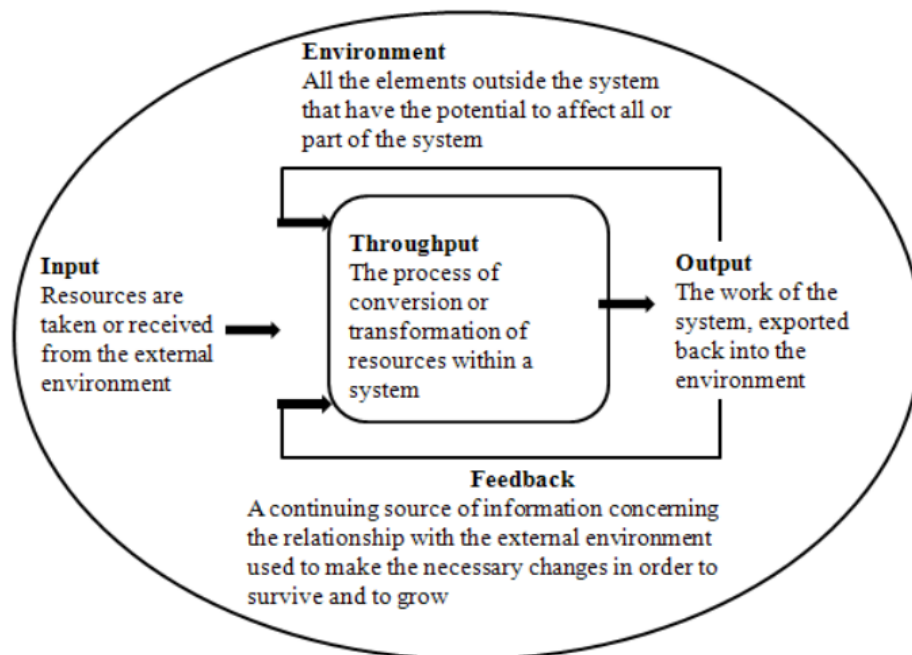


Figure 12: Open Systems Model (Ramosaj & Berisha, 2014, p.61) (CC-BY Creative Commons Licence)

In a systems approach, the CF must manage facilitation within the structures and cultures provided by organisations (Thomas, 2008). However, the external and internal inputs and throughputs will influence how the CF performs their role of

facilitation. The external environment significantly influences how the individual or organisation will respond to the external environment; however as purported by Harcourt and Cornell (2015), there is little that the individual or organisation can do to change this external environment.

In open and closed systems, entropy (or disorder) can occur (Kast & Rosenzweig, 1972). However, entropy is more likely to occur in closed systems as there is no energy received from the external environment to energise the system (Harcourt & Cornell, 2015). In contrast, open systems can receive inputs that stop the process of entropy (Kast & Rosenzweig, 1972). In open systems of healthcare, entropy or disorder is constrained by the adherence to standards, codes and best practice. However, Von Bertalanffy (1968) stipulated that when discord occurs, internal stimuli could drive change rather than relying on the external stimulus of the environment. The inputs of the system should improve communication and cooperation to enhance organisational and individual performance. (Burke & Litwin, 1992; Ramosaj & Berisha, 2014)

Katz and Kahn added 'throughputs' as another component of the systems approach (Ramosaj & Berisha, 2014) and these were reported as social and technical variables. These variables influence how transformational or transactional changes occur (Harcourt & Cornell, 2015) through understanding the connections between parts of the system and the external environment (Burke & Litwin, 1992; Ramosaj & Berisha, 2014). Change is considered necessary for the maintenance of dynamic environments (Ramosaj & Berisha, 2014).

The outputs of the system can include products, services, satisfaction, monetary gain and the integration of objectives or goals of individual components of the system (Harcourt & Cornell, 2015). The effectiveness of the system is determined by the feedback that is received about the outcome. However, interactions and collaboration between organisations and individuals occur within the organisation's or individual's boundaries. This boundary separates the system from the external environment (Harcourt & Cornell, 2015). However, boundaries are seen as permeable and are not always delineated from the social system of organisations (Kast & Rosenzweig, 1972).

Systems theory is essential for understanding the phenomenon of this study as the external environment influences the effectiveness of the CF's interactions and

interrelationships and affects the outcome of student competency and readiness. This outcome is also likely to have a flow-on effect on the provider’s ability with regard to expectations for and how they as a system interact with the external environment. The next theory to be discussed is Facilitation Theory.

2.5.2 Facilitation Theory

Heron (1999) described Facilitation Theory as managing the six dimensions of facilitation: planning, meaning, confronting, feeling, structuring and valuing. The managing of these dimensions occurs in three different ways and as such determines how decisions should be made on each dimension. The hierarchical mode, the cooperative mode and the autonomous mode deal are political modes that describe who controls the decisions: ‘the facilitator alone, the facilitator and the group members together, or the group members alone’ (Heron, 1999, p. 8).

The hierarchical mode occurs early in the facilitation process when much direction is needed for learners or group members. The facilitator alone makes the decisions. The cooperation mode occurs midway as the learner or group members are guided as they have some confidence, knowledge and skills. They participate in decision making and have some control over the decisions with the facilitator. The autonomous mode occurs later as learners obtain knowledge and skills. It is then that the learners or group members control the decisions. Figure 13 sets out the framework for the dimensions and modes for facilitation (Heron, 1999, p. 9).

	Planning	Meaning	Confronting	Feeling	Structuring	Valuing
Hierarchy						
Co-operative						
Autonomy						

**Figure 13: Dimensions and modes for facilitation (Heron, 1999, Figure 1.2, p. 9)
(Permission obtained)**

The six dimensions of Heron (1999) are now described. When the facilitator examines the question of how group members can achieve the objectives set out for them, they act in the dimension of planning. As the facilitator ask questions about group

members' cognitive experiences, they identify further meaning about the experiences and actions of group members; they are operating in the meaning dimension. When questioning aspects of issues of avoidance or resistance, the facilitator behaves in the confronting dimension. The feeling dimension is accessed when they manage their feelings and emotional responses. When the facilitator utilises methods to shape and provide opportunities for learning for the group members, they are seen to operate in the structuring dimension. The valuing dimension is operationalised when the facilitator asks questions and considers values such as integrity and respect.

The next theory to be discussed is Blooms Taxonomy, which is a learning theory. Learning theories are outlined in Fawcett's (2005) category of 'development'. The developmental category of knowledge explains the process of development and maturation.

2.5.3 Bloom's Taxonomy

Bloom's Taxonomy is a theory of learning. Learning theories explain how adults learn and develop within the context of the environment. As the CF supports students in the CLE, learning theories apply not only to the student but also to the CF and how they learn while performing the role of the CF and supporting student learning.

Bloom's Taxonomy consists of three domains of learning: cognitive (knowledge), affective (attitude) and psychomotor (physical) (Bloom et al., 1956). Henry and Murry (2018) confirmed that Bloom's three domains were effective in assisting students to transform experiences in the social settings or contexts in which they are placed. Their illustration of these domains demonstrates the overlap of the domains (see Figure 14).



Figure 14: Bloom's Taxonomy (Henry & Murry, 2018, figure 1) (CC-By Creative Commons Licence)

As the learner becomes more coordinated, their psychomotor performance becomes more natural and automatic. Identifying nursing competency requires that the cognitive, affective and psychomotor domains are assessed. These assessments are conducted in the NCAS of students in WA.

2.5.4 Approaches to Risk

The management of risk sits within Fawcett's (2005) 'intervention category of knowledge'. Risks have been associated with circumstances related to behaviours and consequences of personal, societal or business decisions (Cienfuegos, 2013) or from a lack of adherence or use of resources and processes (WA DOH, 2016). In health setting organisations, the management team is expected to provide the necessary resources to support and keep individuals safe (NMBA, 2007).

As nursing students are learners, nursing supervisors and providers of education and health services will need to manage for the risks. They will need to also make decisions to develop student learning. However, to make correct decisions, the risks and threats must be identified, understood, evaluated and managed within the context in which a risk is likely to occur (WA DOH, 2016).

2.5.4.1 Risk Management Process

In WA, the process to manage risk is outlined for clinical settings in five steps: establish the context, identify risks, analyse risks, evaluate risks and treat risks (WA

DOH, 2016). Although these steps were written specifically for the organisational context, they are relevant to all healthcare professionals (WA DOH, 2016). Individuals and organisations are expected to be transparent and accountable in how they I, A & M issues about the likelihood of risk and its potential effects (see Figure 15).

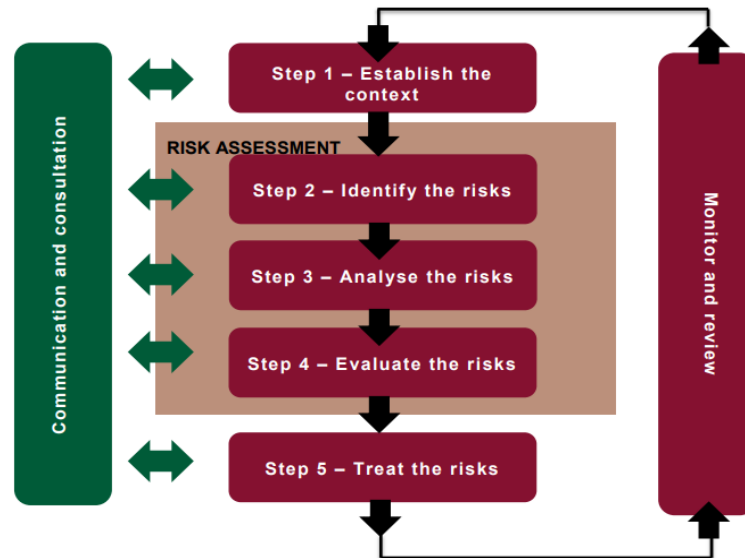


Figure 15: Risk management process (WA DOH, 2016, p. 5) (Copyright to this material is vested in the State of Western Australia unless otherwise indicated)

The next category addresses the needs of individuals to attain competency and capability. The CF is required to have competency in facilitating student development. Likewise, students on a final placement are expected to achieve competency in their nursing skills, their knowledge and their professional behaviour. The framework used to explain this is the Ascent to Competence (Levett-Jones, 2007).

2.5.5 Ascent to Competence

The Ascent to Competence conceptual framework was developed by Levett-Jones and Lathlean (2009) for the discipline of nursing. The Ascent to Competence incorporated an adaptation of Maslow’s (1943) Hierarchy of Needs. Levett-Jones’s (2007) model explains the motivational influences of assisting students to become competent beginning-level nurses. The authors ranked as first the need for safety and security, followed by belongingness, self-concept, learning and competence. Students needed to practice in a safe environment with harmony between their values and the values of the clinicians. They needed to be recognised and respected for their contribution. They needed their environment to be authentic so that they could practice carrying out their

knowledge and skills. These conditions would then enable them to become competent and confident practitioners.

Levett-Jones (2007) added individual, interpersonal, contextual and organisational factors that affected the student's development of belongingness and competency. This recent adaptation is not only pertinent to understanding what motivates students but can be considered in the light of how individuals performing the role of the CF can reach their full potential for the supervision of students in the context of individual, interpersonal and organisational contexts. Figure 16 presents Levett-Jones's (2007, p. 271) model for competency.

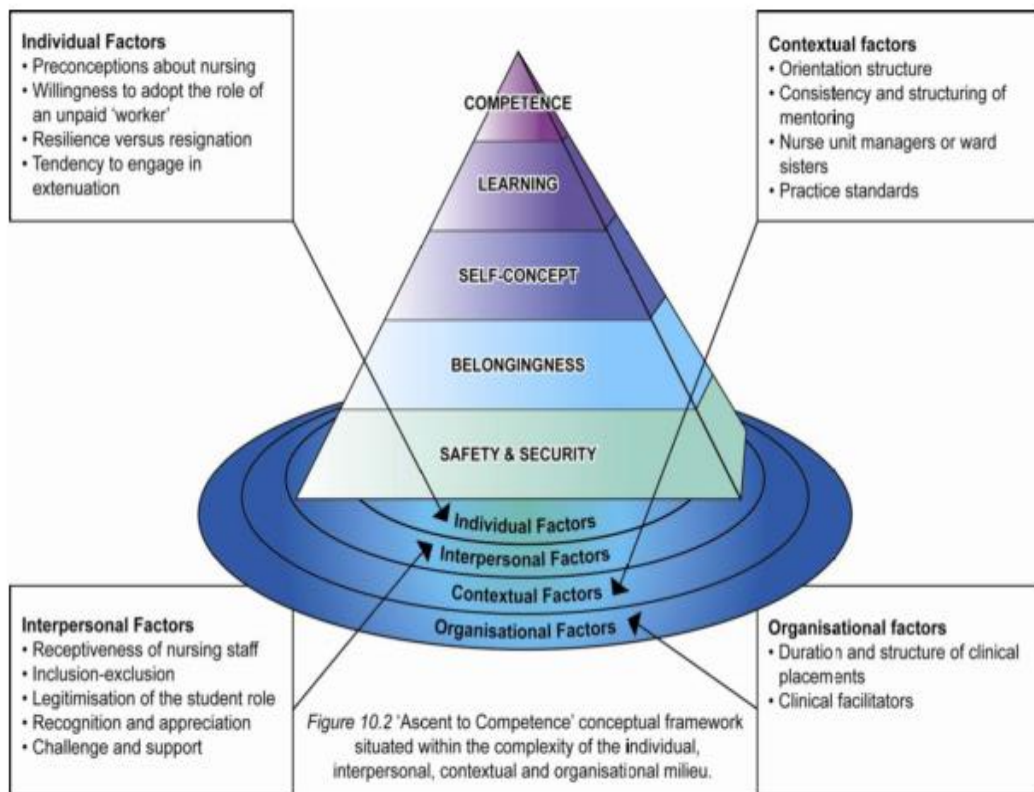


Figure 16: The Ascent to Competency conceptual framework situated within the complexity of the individual, interpersonal, contextual and organisational milieu (Levett-Jones, 2007, p. 271) (Permission obtained)

2.6 Chapter Summary

The aim of this literature review was to seek out information related to the phenomena of facilitating students on their final placement, and the identification, assessment and

management of risks. The search strategy for relevant literature and theories was provided. The literature review identifies what was considered best practice for learning environments and facilitation. The theories describe not only the approaches to clinical facilitation but also the phenomena of student learning and development of competency. The next chapter reports on the methodology.

Chapter 3: Methodology

This chapter follows on from the introductory and literature review chapters. The introduction chapter outlined the background and the purpose of the study. The literature review outlined the historical and practical settings in which CFs must support students on a final practice, and what factors are known that might influence how ready a student is for the role of the RN.

This chapter outlines the research paradigm and methods used to conduct this inquiry. A research design is a blueprint that determines the orientation of the inquiry to explore the phenomenon (Billups, 2014). The purpose of this inquiry was to explore the lived experience of CFs in identifying, assessing and managing risk to final-semester nursing students' readiness to practice.

For my inquiry, I needed to ask, 'What am I trying to understand about the lived experiences of CFs?' and 'What is the best way to uncover, explore and describe this question?'. Two key questions that would assist this exploration were considered. First, what were the CFs' perceptions of the factors that affected the final-semester nursing student's ability to be ready for the role of the RN? Second, how did the CFs I, A & M these factors?

Knowing how to arrive at the answer is determined by the inquiry design. Three sections describe how this inquiry was approached and conducted: the research paradigm, the methods and ethics approval. The research paradigm explains the ontological and epistemological approach chosen for the inquiry and describes how the phenomenological interpretative approach deciphers the meaning of the participants' experiences. The methods section describes the processes used for the collection, analysis and interpretation of the data. Strategies used to maintain rigour through the collection and analysis of data are also outlined. The presentation of ethical considerations concludes the chapter.

3.1 The Research Paradigm

According to Scotland (2012), researchers choose a paradigm that is scientific, interpretative or critical to explain their ontological and epistemological positions.

Punch (2014, p.14) defined a paradigm as ‘a set of assumptions about the social world, and about what constitutes proper techniques and topics for inquiring into that world’. This paradigm is otherwise known as a philosophical stance (Guba & Lincoln, 1994; Scotland, 2012), approach (Laverty, 2003), position (Thomas, 2010) perspective (Guba & Lincoln, 1994; Laverty, 2003) or worldview (Thomas, 2010).

Ontological assumptions consider the state of being and questions what the reality is, while epistemological assumptions consider knowledge and how it is ‘created, acquired, and communicated’ (Scotland, 2012, p. 9). The research paradigm influences how strategies and tools are used to understand phenomena. The reality can be either measured or be one of interpretation. For each part of the research inquiry, the strategies used for ontological approaches will differ. The next section outlines how these research paradigms differ.

3.1.1 Quantitative and Qualitative Approaches

Two contrasting research paradigms were considered: the scientific approach and the naturalistic approach. The most dominant research paradigm is the scientific approach (Denzin & Lincoln, 2018), which is also known as a positivistic or quantitative approach. The ontological viewpoint in this approach is realism; that is, the reality is independent of the researcher. The epistemological viewpoint is one of objectivism, where absolute knowledge about objective reality can be determined (Scotland, 2012).

Researchers who utilise a quantitative approach reveal their assumptions through relative ontology. This approach is one of deduction where the findings are reduced from general instances to more specific instances to predict an outcome (Reiners, 2012). These inquiries are scientific, objective, rational and independent of the context. A research hypothesis is necessary to identify variables and manipulate them (Burns, Brand, & Millard, 2010). The various types of quantitative studies are exploratory, descriptive, correlational, quasi-experimental and experimental (Grove, Burns, & Gray, 2012). The science disciplines perceive the positivistic approach as more substantive and more established (Burns & Grove, 1993; Smith, Flowers, & Larkin, 2009) than other approaches as this type of enquiry relies on facts (Forrester, 2010).

Forrester (2010) used a metaphor of stopping at traffic lights to describe the positivist approach. A positivist approach only tells us that individuals have stopped but does not explain why they have stopped. Positivists might be able to associate patterns with conditions, but individuals will stop for a variety of reasons. These reasons may not be related to rules but to penalties, safety, weather, past experiences or changing circumstances. These influencing factors may be dependent on a specific time or event and link to social and background contexts. The positivist approach does not capture individual perspectives about the social or historical factors that have influenced the truth about reality (Denzin & Lincoln, 2018).

To account for social, historical or other contexts surrounding individuals, researchers use a naturalistic (Grove et al., 2012) or interpretative approach (Smith et al., 2009). The epistemological assumption is that an individual's experiences will vary from those of other individuals as causality can be varied and can occur in a shared context with other individuals (Forrester, 2010). Qualitative approaches do not rely on having the one truth but rely on many truths to describe how reality might exist for a group of individuals (Speziale & Carpenter, 2007).

When using the qualitative approach, researchers must use strategies that are flexible to capture the realities of experiences (Brink & Wood, 1988). The capturing of experiences occurs through a variety of approaches (Speziale & Carpenter, 2007). These approaches can incorporate paradigms and methods of both rational and naturalistic approaches.

Speziale and Carpenter (2007) identified six essential characteristics of qualitative studies. These characteristics include believing that multiple realities about a phenomenon will exist, using the best approach, exploring participants' viewpoints, using natural environments or relevant contexts to prevent disruption, recognising the researcher's involvement in the inquiry, and using narratives or a literary style of writing to illuminate the phenomenon. Some ways to approach qualitative research are ethnography, grounded theory, historical or phenomenological studies. However, the philosophical positions that individual researchers take will influence how their interpretations are made (Speziale & Carpenter, 2007).

This study sought the underlying meanings of CFs' experiences. As quantitative or relativism deals with numerical and logical approaches, more profound meanings about the contextual issues that influence the turning towards or away from identifying, assessing and managing risk were required. The naturalistic or qualitative stance is used extensively in the social sciences (Denzin & Lincoln, 2018) and appeared more appropriate for this inquiry. This approach encompasses an interactive process where analysis consists of comprehending, synthesising, theorising and contextualising the data to make sense of the participants' lived experience (Grbich, 1999a).

This next section outlines the philosophical approach of phenomenology as a lived experience, to seek out the essence of the experience.

3.1.2 Phenomenology

Edmund Husserl was reported as being disillusioned with traditional ways of researching the sciences and developed a different way to think and respond when studying individuals (Vandermause & Fleming, 2011). The underlying activities and meanings behind a phenomenon were reported by Speziale and Carpenter (2007) as 'an approach that can be used to study lived experience. His [Husserl's] followers believe that the purpose of phenomenology is to provide pure understanding' (p. 25).

This inquiry occurred in a natural setting; one with which the participants were familiar (Orb, Eisenhauer, & Wynaden, 2001). A natural setting was used to conduct interviews and to minimise intrusion (Speziale & Carpenter, 2007, p. 22). Husserl's intent was that this naturalistic setting would allow the participant to 'open up' and, through 'eidetic reduction', get at the 'core' or the 'essence' of a given phenomenon (Smith et al., 2009, p. 14). Husserl was seeking an individual's awareness of the phenomenon (Smith et al., 2009).

If we consider Forrester's (2010) metaphor of stopping at traffic lights, the naturalistic researcher can describe the essence of stopping at red traffic lights. These essences will be derived from individuals' descriptions of their experiences (Reiners, 2012). However, as the researcher is interpreting from a personal background of driving experience, their previous experiences of stopping or not stopping at red lights might bias or influence how effectively they listen to and interpret participants' descriptions.

The researcher may look for experiences that reflect their descriptions rather than seeing the 'essence' or experiences that are unique to the group of participants.

Brink and Wood (1988) suggested that researchers need to understand the effect of their bias on the quality of the study. Guba and Lincoln (1994) expected the perspectives of the researcher to be identified and made explicit throughout the inquiry. Researchers are to set aside, suspend or bracket their understandings or knowledge about the world, to constrain bias or misinterpretation. The suspension of the researcher's experiences or knowledge allows the researcher to listen attentively to an individual's story. This action was described as actions of 'bracketing' or 'reduction' (Vandermause & Fleming, 2011, p. 369), which allows the researcher to see through a different lens the essence of the phenomenon (Smith et al., 2009).

Polit and Beck (2008) supported Husserl's actions of bracketing and recommended researchers use a reflective journal to identify and keep in check their beliefs and opinions. Lincoln and Guba (1985) encouraged researchers to identify their assumptions and make them explicit throughout their reflections and the inquiry. These assumptions are the taken-for-granted understandings with which the researcher is familiar and which although they exist are set aside to focus on participants' experiences (Smith et al., 2009).

Chan, Fung and Chien (2013) recommended that researchers use strategies for the process of bracketing to prevent bias from occurring. However, Tufford and Newman (2010) admitted that a lack of consensus existed about the use of bracketing. They concluded that bracketing was a 'multi-layered process' that occurred more than once. As such, bracketing could occur before the interview began, during the interview and throughout the inquiry by using others to review transcripts, or by using a reflexive journal to identify biases and assumptions or taking notes about insights and observations.

Although Martin Heidegger studied under Husserl, he deviated from the Husserlian perspective of suspending one's assumptions. Heidegger focussed on capturing the specific meanings individuals had made about their experiences, not just the description of them. Reiners (2012) contrasted Husserl's descriptive approach about

the essence of the lived experience to that of Heidegger's interpretative approach where he sought the meaning of everyday occurrences.

Larkin, Watts and Clifton (2006) outlined how Heidegger disagreed with separating out 'a person-in-context' with other individuals and things (p. 106). Reiners (2012) suggested that bracketing in an interpretative phenomenological analysis (IPA) inquiry should not occur when trying to interpret the meaning of the experience. Unfortunately, the use of the term 'bracketing' in descriptive and IPA studies is inconsistently applied among researchers and may be confusing for novices (Tufford & Newman, 2010). Although the setting aside of experiences did not occur in this study, similar actions such as using self-interview, reflection and reflexivity were used to identify current understanding or bias. This is further explained in the methods section.

The next section outlines why Heidegger's IPA was chosen and describes the central concepts. The approach extends Husserl's approach to the lived experience in which he was seen to question and explore the nature of being human in the context of time (Smith et al., 2009).

3.1.3 Interpretative Phenomenology

Thomas (2010) recognised that the philosophical basis of interpretivism consisted of both phenomenology and hermeneutics. The intent was to describe what was at the surface and to uncover what was hidden (Smith et al., 2009). According to Reiners (2012), a researcher would use this approach when wanting to ascertain how someone understood relationships.

There are many ways to conduct an interpretative inquiry. Denzin and Lincoln (2018) reported that this type of inquiry arose from interpretative perspectives that focussed on specific theories such as feminist or critical race theory. However, Smith and Osborn (2007) reported there was no one way to conduct the inquiry.

Although Husserl's approach enables researchers to describe the experiences, phenomenology by itself is unable to capture in-depth meaning about the experiences. In contrast, Heidegger's interpretative approach allows researchers to capture in-depth meaning about the experience; for example, how people learnt to stop or learnt the

rules about stopping at red traffic lights (Forrester, 2010). Speziale and Carpenter (2007) mentioned that qualitative researchers appreciate that multiple perceptions of reality do exist, and that those meanings are different for everyone.

In explaining the reality about experiences, Smith et al. (2009) proposed that in the context of an individual's environment and social relationships, inter-subjectivity occurs as a shared, overlapping and relational engagement between individuals and inanimate entities of the world (Smith et al., 2009). The researcher uses the outsider or etic viewpoint to interpret the participant's viewpoint: 'This everyday ordinary existence provides the interpretive phenomenological researcher with the opportunity to inductively reveal meaning from the emic perspective' (Horrigan-Kelly, Millar & Dowling, 2016, p. 7).

Heidegger's approach comes from a 'worldly' perspective, where meaning is derived from what already is:

Thus we might characterise Husserl as primarily concerned with what can be broadly classified as individual psychological processes, such as perception, awareness and consciousness. In contrast, Heidegger is more concerned with the ontological question of existence itself, and with the practical activities and relationships which we are caught up in, and through which the world appears to us, and is made meaningful (Smith et al., 2009, pp 16-17).

Heidegger's ontological approach is one of accepting that a participant's experience is merely a part of them Being-in-the-world where there are no rules to define their experience and where they can make sense not only of themselves but of another's experiences. In this study, my awareness of the practical activities and the relationships arise from having been involved in the facilitation process, which will assist in identifying implicit meanings from the experiences of others. Therefore, this study used an inductive approach to examine the details of the experience and make broad explanations about the phenomenon. Smith et al. (2009) reported that broad conclusions would arise from the text when iteration and re-reading occurred (Polit & Beck, 2008; Speziale & Carpenter, 2007).

In this section, key Heideggerian terms are explored: 'Dasein', 'Being', 'Being-in-the-world', 'temporality & having concern', 'Heidegger's modes of Being' and the

‘researcher as central to the inquiry’. These key terms describe what it means to engage and exist in the world according to Heidegger’s interpretative phenomenology. Figure 17 illustrates my interpretation of Heidegger’s ‘Being’ and ‘Being-in-the-world’.

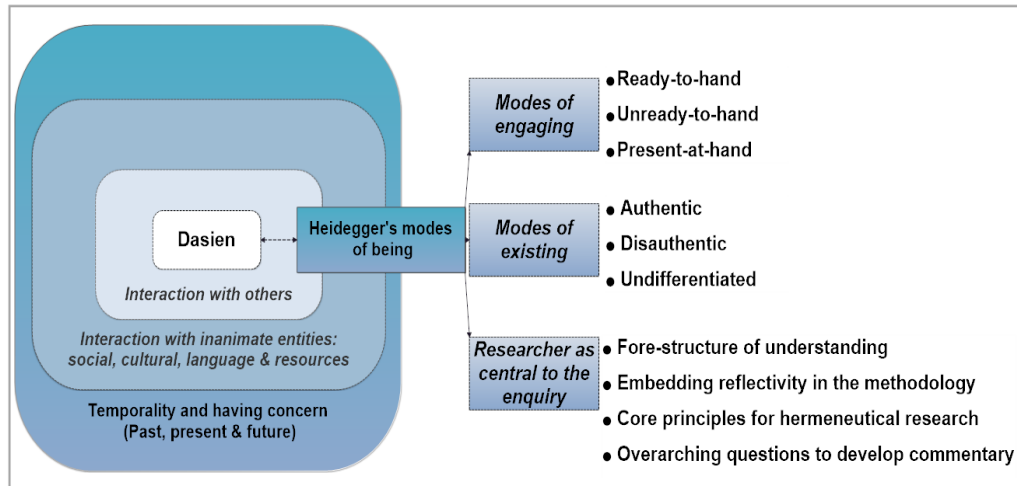


Figure 17: The researcher’s interpretation of Heidegger’s ‘Being’ and ‘Being-in-the-world’

To show how individuals exist and engage through Being and Being-in-the-world, broken lines of each section illustrate Heidegger’s concepts of existing and engaging alongside other individuals and inanimate entities. The researcher is central in this diagram as their background of Being and Being-in-the-world influences how they make sense of participants’ experiences.

3.1.3.1 Dasein

Dasein appears to be at the centre of Being and Being-in-the-world. Horrigan-Kelly et al. (2016) re-iterated Heidegger’s view of Dasein as a ‘living being’, one that is actively engaging with ‘Being-in-the-world’ (p. 2). Dasein is considered an ‘entity’ that situates in the context of time and with others of similar contexts (Heidegger, 1926). Individuals are influenced by the social context, by culture and by language (Smith et al., 2009), or through encounters with others, equipment and nature (Horrigan-Kelly et al., 2016).

In this inquiry, Dasein refers to the participants, who engaged with others to facilitate students on final placement. Dasein also refers to the researcher engagement with the participants’ experiences. Both the participant and the researcher are entities that are

situated and influenced by the social and cultural environments, by equipment and by time. Horrigan-Kelly et al. (2016) cited Heidegger and stated that this everyday existence occurs in the context of 'Being' (Horrigan-Kelly et al., 2016, p. 2) or of 'Being with' others (Horrigan-Kelly et al., 2016, p. 3).

3.1.3.2 *'Being' and 'Being-in-the-world'*

Heidegger (1926) considered that the characteristics of Being were 'everything we talk about, everything we have in view, everything towards which we comport ourselves in any way' (p. 26). Heidegger assumed that one's 'Being-in-the-world' involves being in relationships with people or inanimate entities, and that the context of these relationships will determine the meaning (1926, p. 79). Non-entities that are not related to the human being, or Dasein, are those related to social, environmental and historical instances that influence one's way of Being.

Heidegger examined 'how human beings construct and give meanings to their actions in concrete social situations' (Denzin & Lincoln, 1994, p. 204). Ajjawi and Higgs (2007) considered that 'real workplace and professional interactions' were such instances where an individual's context of situation and practice had influenced their 'Being-in-the-world' (p. 15). To this end, we exist 'factically' with others where one can understand 'our own as well as other's destiny [as] we "dwell alongside" other persons' (Conroy, 2003, p. 7).

Heidegger interpreted what it meant for individuals when their world was 'influenced by everything internal and external to the individual' (Speziale & Carpenter, 2007, p. 77). Parsons (2010) also concluded that Being-in-the-world meant that individuals would engage in ways that were meaningful or important to them (p. 68). According to Vandermause and Fleming (2011), Being-in-the-world type of inquiries require the researcher to discover the truth through interpretation and, according to Heidegger (1926), taking into consideration time and its influence on an individual's concerns.

In this inquiry, what participants spoke about would show how they existed alongside others. Before this study commenced, the ways in which I had engaged or interacted with individuals and inanimate entities had been identified. In this study, my focus was to reflect on, question and make connections about the participants' engagement with individuals such as students, HSS and inanimate entities.

3.1.3.3 Temporality and Having Concern

Heidegger recognised that an individual is influenced over time by experiences and social contexts that reshape and change their perceptions and concerns about their world. Heidegger (1926) described that the central problem of understanding is that ‘ontology is rooted in the phenomenon of time’ (p. 40). Heidegger termed this as having ‘temporality’ where an individual is situated in time that ranges from the past to the future (Blattner, 1979; Horrigan-Kelly et al., 2016). Smith et al. (2009) identified that temporality was an evolving experience and always occurred in connection to something. Blattner (1979) suggested that temporality included more than the usual notion of everyday time and was related to being concerned about aspects of ‘Being’ and of ‘Action’.

Hornsby (1991) reported that having an awareness of one’s temporality influenced how an individual was concerned with the world and with others. However, Reiners (2012) explained that similar experiences between individuals will not necessarily produce the same meanings as individuals come from different social and environmental contexts. The contextual influences would relate to concern about one’s future potential (Horrigan-Kelly et al., 2016; Whitehead, 2004). Concern about one’s way of being would change and Whitehead (2004) indicated that truth in this type of inquiry exists in a moment in time.

In using Forrester’s (2010) metaphor of not stopping at traffic lights, the researcher might investigate why individuals had stopped at red traffic lights. The number of incidents might reflect how safe or unsafe a driver felt when approaching a set of lights. However, in other locations the number of incidents or the sequence or timing of the lights might have varied, which influenced how drivers may or may not have concern. This example shows that truth is situated within aspects of context and time.

Although the temporality of truth is likely to limit the generality of this inquiry to a broader population, this approach will be relevant to a small homogenous group with similar contextual surroundings. In this inquiry, CFs were likely to have concerns that were similar, that were different or extended my own understanding about such concerns.

In this inquiry, my engagement with the present experience of participants helped me to make sense of participants' experiences and to make new meanings from this engagement. However, the truth about a phenomenon is also subjective and related to how an individual engages or exists in their world. The next section outlines Heidegger's explanation for engaging, existing and being concerned in everydayness.

3.1.3.4 Heidegger's Modes of Being

Heidegger established the modes of Being to show how thrown together individuals are in a world amid a myriad of entities and other 'daseins'. An individual engages with the familiar and the unfamiliar in everyday activities. Unfamiliarity or familiarity with everyday engagement is further influenced by one's concern with existing and reaching their fullest potential. The next two sections outline the 'modes of engaging' and the 'modes of existing'.

3.1.3.4.1 Modes of Engaging

Both Parsons (2010) and Conroy (2003) described Heidegger's modes of engaging as ready-to-hand, unready-to-hand and present-at-hand (see Figure 17). The modes of engaging show how individuals will manage in situations where they exist consciously or are oblivious to ways of existing with individuals and inanimate entities. In this study, both the researcher and the participants operated in these modes of engaging. In this study, the use of reflexivity guided me in understanding more about my own responses. During the study, I set out to examine how CFs I, A & M risk with others and factors such as equipment, processes or systems. This can be interpreted from the way in which they encountered obstacles.

The behaviours relevant to each of the modes of engaging are further defined in the modes of 'ready-to-hand', 'unready-to-hand' and 'present-at-hand' (see Figure 18).

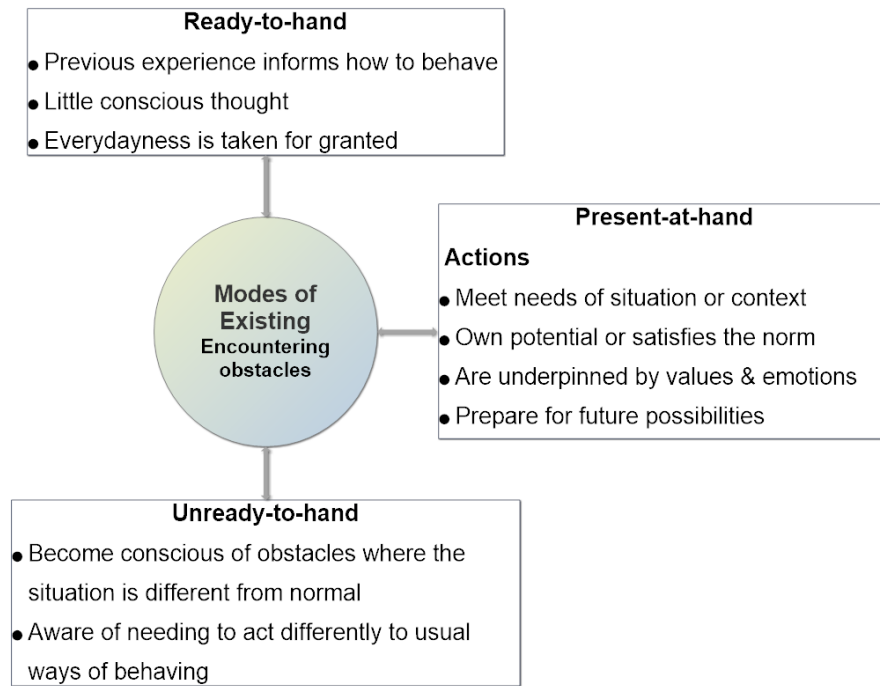


Figure 18: The researcher’s interpretation of Heidegger’s modes of engaging

Heidegger explained understanding by using the metaphor of a hammer and hammering (Conroy, 2003). The hammer’s function is to be used by an individual for driving nails into a wall. For example, if an individual has done this before and is reasonably adept the action performed will occur with little conscious thought. Heidegger termed this mode ‘ready-to-hand’. This mode is identified when an individual takes for granted the things in their experiences and where the real meanings are obscured through ‘everydayness’ (Parsons, 2010, p. 61).

As the individual engages with the hammer, the nail and the wood, they may encounter obstacles: the nail might bend because the wood is hard or a knot is present, or the hammer may have an unfamiliar balance. Parsons (2010) suggested that in this mode what was invisible has now become visible and arrives at the conscious level. Heidegger termed this the ‘un-ready-to-hand mode’. Conroy (2003) added that when a person experienced a situation differently from their previous encounters, they may react in unfamiliar ways to overcome obstacles.

When individuals become cognisant or aware of their behaviour, they are then able to adjust to the situation or the context (Conroy, 2003). The individual then makes slight adjustments to the way they hold or angle the hammer or apply pressure. Heidegger termed this mode as being ‘present-at-hand’. Adjusting to fit the context can be

moderated by the values held greatest by an individual. These values described by Michie and Gooty (2005) included universal values related to those in and outside of groups such as ‘social justice, equality, and broadmindedness’ (p. 443), as well as benevolent values such as ‘honesty, loyalty [and] responsibility’ (p. 445, figure 1).

However, Michie and Gooty (2005) suggested that emotional states influence behaviours. They reported that gratitude, appreciation and goodwill might conflict with universal or benevolent values that are related to systematic, organisational or workplace expectations. An individual is likely to prioritise these values in the context of their concerns or to conform to others’ concerns (Heidegger, 1926). Conforming or satisfying the norm can apply to social, cultural, organisational and systematic expectations. Hornsby (1991) identified these actions as either authentic or inauthentic existence.

In this inquiry, the ability of CFs to engage with the workplace environment, people or inanimate entities was significant. As a CF became aware of the problems (the unready-to-hand mode) they were or were not able to manage for these obstacles. If CFs became aware of the need to act differently (present-at-hand mode), they would develop an already-to-hand mode where they automatically dealt with the relevant issues. The ability to deal with issues in the present influenced how they can deal with issues in the future.

3.1.3.4.2 Modes of Existing

Both Parsons (2010) and Conroy (2003) described Heidegger’s modes of existing as assisting the researcher to see how an individual sees and copes with their world. Hornsby (1991) reiterated that these modes are grounded in a way of Being (Heidegger, 1926) and reveal how individuals can reach their potential for wholeness. Blattner (1979) identified these modes of Being as related to ‘time and temporality’ (p. 22). As individuals interpret and respond to their experiences, they can exist and move sufficiently or insufficiently between these modes. When the move is insufficient, it is to minimise one’s concerns (Heidegger, 1926).

To exist in deficient modes and to ignore a way of Being is likely to produce distress or anxiety (Conroy, 2003). Conroy (2003) saw distress as implicit anxiety, which is

seen in nonverbal or verbal cues. She stated it was necessary to look beyond what was said and to examine what it meant for authentic engagement with the real world.

An interpretation of Heidegger’s ‘three (unsettled) modes of existing’ or ‘taking a stand’ (HTMETS) is illustrated in Figure 19; the ‘authentic mode’, the ‘inauthentic mode’ and the ‘undifferentiated mode’ have aspects related to inauthentic and authentic modes of existing.

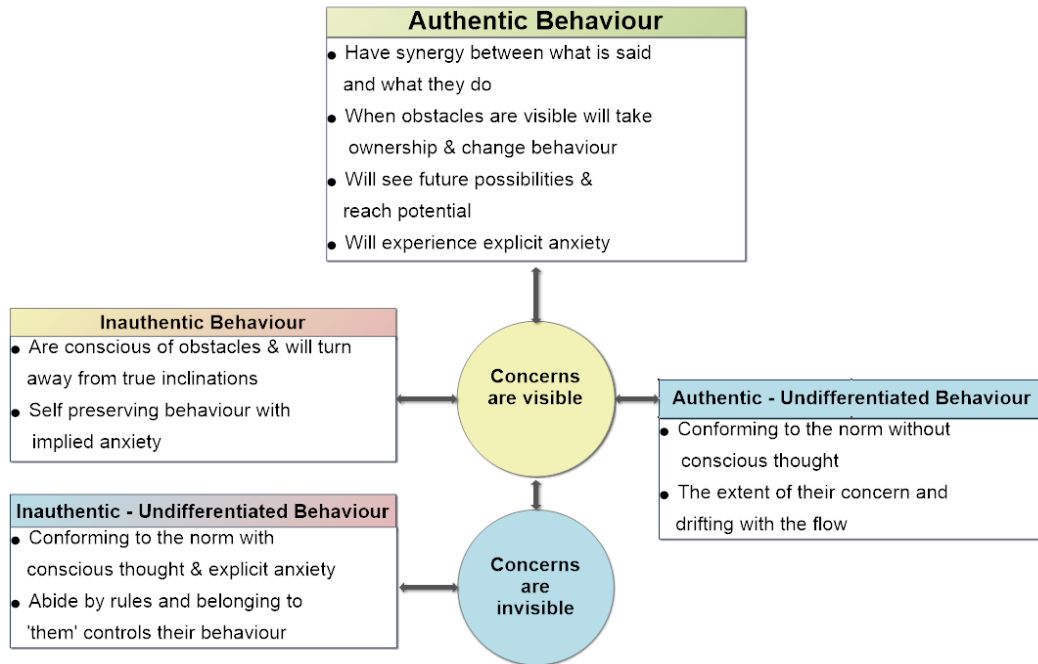


Figure 19: The researcher’s interpretation of Heidegger’s modes of existing

Conroy’s (2003) table of HTMETS (p. 38) was modified by replacing each of Conroy’s (2003) bullet points with an allocated number. This numbering approach aids the reader when the HTMETS is referred to throughout the methods section. These modes of existence are outlined in Figure 20.

<p style="text-align: center;">AUTHENTIC ‘Own up to’ Synergy between what one says and does Genuineness Eustress</p>	<p style="text-align: center;">INAUTHENTIC ‘Disown’ Discord between what one says and does Hiding one’s genuine inclinations Distress</p>	<p style="text-align: center;">UNDIFFERENTIATED ‘Fail to take a stand on’ Passive conformity to cultural ‘ways of doing’ N. B. Being exists in this drifting mode most of the time</p>
<ol style="list-style-type: none"> 1. achieves individuality 2. genuine ownership of a way of thought 3. realises one can never find meaning by identifying oneself with a role 4. chooses the social possibilities available so as to manifest within activity, one’s understanding of the groundlessness or vagueness of one’s existence 5. can choose one’s way and win 6. self is an unfolding event, in the process of realisation 7. engaged agent 8. actively assumes a range of possibilities open to oneself 9. set of personality traits 10. lifestyles, roles, attitudes 11. future oriented 12. assumes control of situations with resoluteness and dedication for one’s goals 13. a ‘Person-in-relation’ attuned to a quest for shared community values: fairness, honesty, dignity, benevolence, achievement 14. coherence, cohesiveness, integrity to a life course 15. life is a coherent story; actions are a part of being a person of a certain type 	<ol style="list-style-type: none"> 16. adopts the public identities offered by society as a way to flee one’s agitation 17. actively identifies with social roles which allow one to ignore one’s true nature and interpretations of Self 18. only appears to have control over one’s life events 19. Self is an object 20. disengaged agent 21. actions are physical movements explained in terms of inner beliefs, desires, feelings 22. sharp distinction between body and mind 23. atomist view of human agency 24. prefers involvement in public forms of life 25. levels all decisions to the lowest common denominator of what is acceptable 26. life experienced as an episodic sequence of calculated strategies lacking any cumulative significance or overriding purpose 27. trivializes the present by preoccupation with ‘the carrot at the end of the stick’ 	<ol style="list-style-type: none"> 28. passive formation by public interpretations 29. socialisation into a particular cultural understanding 30. always anxious about one’s own feeling of being unsettled 31. not focussed on one’s anxiety 32. stand is just what one picks up from the public 33. collective way of disowning responsibility 34. can lose but never win oneself 35. tends to ‘go with the flow’ 36. content to satisfy the easily handled rules, public norms and thereby disburden oneself of all responsibility 37. humdrum routines 38. obliterates the 2 tiered sense of life that lets us distinguish higher/lower, crucial/trivial, central/peripheral 39. ensnared in immediate concerns to drift with taken-for-granted practices 40. tasks, rules, standards, public norms provide the impetus for and the extent of concern and solicitude 41. occultness 42. absorption with things/ techniques/ procedures 43. unreflective oblivion

Figure 20: Heidegger’s ‘three (unsettled) modes of existing’ or ‘taking a stand’ (Adapted from Conroy, 2003, p. 38) (CC-BY Creative Commons Licence)

3.2.3.4.2.1 Authentic Modes of Existing

Authentic engagement is a mode of engagement where an individual has ‘synergy between what one says and does’. Authentic actions were stated by Conroy (2003, p. 9) as ‘Eustress’, which ‘is a positive stress which impels one to act authentically’. For example, authentic behaviour can be seen or heard as that of an ‘engaged agent’ (HTMETS #7; Figure 20) where participants are seen to be actively engaged in behaviour that is synergistic with not only what they say, but what they believe. This behaviour implies that to be an engaged agent and to do what they expect can still produce stress. During this study, the questioning and analysing of data were undertaken to ascertain what values participants referred to when they identified, assessed or managed risk to student readiness. From the turning towards or away from these values, authenticity would be interpreted.

3.2.3.4.2.2 Inauthentic Modes of Existing

Being inauthentic or ‘fallen’ is Heidegger’s second mode of engaging (Horrigan-Kelly et al., 2016). Heidegger postulated that although an individual orientates themselves towards their possibilities, individuals embracing the norms of others may fail to discern or set themselves apart from others (Hornsby, 1991). Accountability for one’s actions was not taken as one’s responsibility. Heidegger postulated that the resultant anxiety would drive individuals to behave in ways that were self-preserving. Horrigan-Kelly et al. (2016) considered conformance as losing a sense of self. For example, HTMETS #17 is tabled as ‘actively identifies with social roles which allow one to ignore one’s true nature and interpretation of Self’ (Figure 20). This behaviour may show up where individuals might struggle in the workplace environment and consequently act in a manner that is not congruent with their beliefs, with their role expectations or with their normal behaviour. For this individual, their practice or behaviour is at odds or in discord with what they believe. Conroy pointed out that where discord of this nature occurs, the individual will experience ‘negative stress’ or anxiety (Conroy, 2003, p. 26). The current study sought to identify instances where individuals consciously turned away from authentic behaviour and had experienced distress in identifying, assessing and managing risk to the readiness of students

3.2.3.4.2.3 Undifferentiated Modes of Existing

The third mode of existing is one where Heidegger considered that individuals did not see (Heidegger, 1926) or have awareness, but instead adopted a way of Being as expected by society, agencies or bureaucracies in the form of ‘habit, by rote, or under orders’ (Conroy, 2003, p. 8). The current study sought out instances where CFs may operate in this undifferentiated mode while identifying, assessing and managing risk on a final placement. Conroy explained that various combinations of undifferentiated modes can occur alongside authentic and inauthentic modes.

The inauthentic–undifferentiated mode is where individuals conform to the norm with conscious thought. In this inquiry, the CFs’ ability to consciously consider and act in ways to move students forward was likely to be significant as they could influence the way that a student could progress. Being concerned, but not doing anything about this concern, can imply anxiety. It is only when they became conscious of certain parts of this experience could they choose to turn towards more authentic engagement and support the student to become ready for the role of the RN.

Authentic–undifferentiated mode is where individuals conform to the norm without conscious thought. This study sought instances where authentic–undifferentiated engagement could occur. Such an example would be when a CF attended to the rules or appearance for support rather than critically reflecting about the ethical or practical implications of theirs or other nurse’s actions. Following the rules or actions of other nurses may have been the extent of their concern. This lack of concern may not be enough to assist students to become prepared for the role of the RN. For example, HTMETS #40 is tabled as ‘ensnared in immediate concerns to drift with taken-for-granted practices’ (Figure 20). This behaviour may show up in the workplace environment or facilitation practices as drifting along. The cultural ways of doing and being explain when the individual is unaware or aware of the social or environmental issues that will influence their behaviours. Throughout the study findings, how participants turned towards or away from authentic behaviours is described.

The next section outlines how the researcher is central to the hermeneutical inquiry. Pringle, Drummond, McLafferty and Hendry (2011) considered that the researcher’s action is to understand an individual’s interpretation of their events, and then to make

an interpretation about the participants' meanings. This is similar to a double interpretation, which can provide further insight into how individuals make sense of their experiences.

3.1.3.4.3 Researcher as Central to the Inquiry

A double interpretation occurs when the researcher uses their pre-existing knowledge and experience to make deeper connections about what others have experienced (Smith & Osborn, 2007). A double interpretation is one where the researcher undertakes analysis and interpretation in an 'always-already engagement of making meaning' where making meanings is a part of Being-in-the-world (Vandermause & Fleming, 2011, p. 369). Larkin et al. (2006) considered that an individuals' identity will be understood by the roles and functions they perform.

When the researcher is central to the inquiry, the researcher brings with them their experiences and knowledge, which Heidegger termed 'fore-structure'. This study intended to make explicit what was implicitly known. Also, I used reflexivity throughout the inquiry and made interpretations to formalise and describe the phenomenon.

3.2.3.4.3.1 Fore-structure of Understanding

Heidegger's threefold structure of interpretation: the structure of understanding was utilised in this study and consist of the researcher's knowledge that arises from concepts such as 'fore-having', 'foresight' and 'fore-conception' (Conroy, 2003). These concepts are outlined in Appendix A. In this study, I understood clinical facilitation as I had previous experience or knowledge about the phenomenon (fore-having). This shared experience with other individuals assisted me with knowing ahead of time what the phenomenon may mean (foresight). Foresight can also occur as the researcher can see other possibilities (fore-conception) about what the experiences may mean (Vandermause & Fleming, 2011). Smith et al. (2009) stated 'Thus the reader, analyst or listener brings their fore-conception (prior experiences, assumptions, preconceptions) to the encounter, and cannot help but look at any new stimulus in the light of their own prior experience' (p. 25).

It is this spiralling context, or the past, the present and the future with individuals and entities that assists with the interpretations. The understanding is always present and cannot be ignored, isolated or set aside (Smythe, Ironside, Sims, Swenson, & Spence, 2008). Conroy (2003) reminded readers that an individual's background influences how they can 'pick up or assume meanings' about another's world (p. 9). When researchers are central to using their understanding to make interpretations, they further explore and expand on meaning about the phenomenon.

In this study, my rich experience as a CF deepened my understanding about the contextual influences. Understanding involved reflecting on the relationship I had with individuals and objects or processes. Further understanding and meaning arose from the actions that were taken by participants. In this inquiry, I was able to make explicit what at times was only implied in the narratives of participants. Without having personal experience of the phenomenon, I would not have been able to make sense of the interconnections, implications or meanings behind these experiences. In this study, my experiences were not set aside but were used to question more deeply the meanings individual participants had made about their experiences. This process incorporated reflection during each area of the inquiry to make explicit how interpretations were made from participants' experiences.

3.2.3.4.3.2 Embedding Reflexivity in the Methodology

Mantzoukas (2005), Brocki and Wearden (2006) and Smith et al. (2009) all supported the use of reflexivity without the inclusion of bracketing. Although the philosophical approaches of Husserl and Heidegger differ, it appears that both supporters and non-supporters of bracketing would utilise steps to discover assumptions and to use reflexivity during the inquiry (Conroy, 2003; Smythe et al., 2008; Tufford & Newman, 2010). The major difference in interpretative research is that the researcher does not set aside their fore-structure of understanding, but instead embeds reflexive thought throughout all stages of the enquiry, not to prevent bias, but to inform, make sense of and extend conscious thought about what the participants' experiences might mean. Reflection is then seen to become reflexive where the researcher is aware of their ideological position and how this has shaped their study (Mantzoukas, 2005).

My experiences may not have been the same as other CFs, but this interpretative inquiry required an understanding of what assumptions I had made. Exposing these assumptions up front enabled the focus to remain on the participants' experiences and to explore hidden meanings that were not initially obvious. It enabled a greater understanding of the phenomenon than what I had initially assumed.

Husserl's and Heidegger's approaches were examined to determine which method would best address the research questions. Phenomenology would assist in describing the phenomenon, but the interpretative approach would provide the meaning of the phenomenon. Pringle et al. (2011) concluded that IPA would assist nurse researchers to better hear and understand participants. It would also contribute to the formation of a theory and was likely to expand on services needed to support individuals. For these reasons, the IPA methodology was considered appropriate for this inquiry.

Conroy's (2003) approach to IPA appears to be less known. Conroy compiled a list of core principles that would assist researchers to consider more deeply their involvement in the research process. These core principles were utilised as a tool to guide this inquiry.

3.2.3.4.3.3 Core Principles for Hermeneutical Research

A selection of Heideggerian ideas from experts such as Dreyfus (1991), Gadamer (1989), Hall (1993), Heidegger (1926), Hoy (1993) and Taylor (1989, 1993) were compiled by Conroy (2003). She tested these hermeneutic principles for research (HPR) for rigour in a pilot inquiry and concluded that both the principles and commentary tools met the purpose of helping novice researchers stay true to the Heideggerian approach. An example of one of these principles is to 'seek understanding of the participants' world of significance through immersion in their world' (Conroy, 2003, p. 11) (see Figure 21). Conroy (2003) recommended that researchers should regularly review the HPR throughout an enquiry to ensure rigour occurs. These are described further in the methods section.

<ol style="list-style-type: none"> 1. 'Seek understanding of the participants' world of significance through immersion in their world' (Conroy, 2003 citing Addison, 1992., Benner, 1994). 2. Make explicit the shared world of understanding between the researcher and the researched (Conroy, 2003). 3. Immerse oneself in the hermeneutical circle throughout the research spiral. (Conroy, 2003). 4. Make explicit the immersion of the researcher in the hermeneutical spiral. (Conroy, 2003). 5. Draw out what is hidden within the narrative accounts and interpret them based on background understandings of the participants, and the researcher. 6. <u>Enter into</u> an active dialogue with participants, the trustworthy checkers, and the researchers' interpretations without increasing the risk of discomfort to participants or exposing identities of participants. 7. Maintain a constantly questioning attitude in the search for misunderstanding, incomplete understandings, deeper understandings (Conroy, 2003 citing Addison, 1992; Benner, 1994). 8. Move in a circular progression between parts and the whole, what is disclosed and hidden, the work of the participant and the world of the researcher (Conroy, 2003 citing Leonard, 1994). 9. Engage the active participation of the participants through participation in the research process: the implementation and the interpretation (Conroy citing Plager, 1994). 	<ol style="list-style-type: none"> 10. Encourage self-reflective practice by the participants through participation in the research and through offering an overview of the researchers' understandings and interpretations. 11. View every account as an interpretation based on a person's background (Conroy, 2003 citing Plager, 1994). 12. View any topic narrated by the participant as significant at some level to the participant (Conroy, 2003). 13. Deem every account as having its own internal logic; whatever is brought to an interview is significant to its bearer, consciously or not (Conroy, 2003). 14. Access and make explicit participant understandings through their own modes of existence, mode of engagement while being sensitive to one's own modes of existence and of engagement and foregrounding (Conroy, 2003). 15. Be aware of one's own use of coping tools in any of the modes of existing (Conroy, 2003). 16. Engage in the spiral task of hermeneutical interpretation along with the participant (Conroy, 2003). 17. Keep track of movements in understanding (Conroy, 2003 citing Benner, 1994). 18. Work with participants to see which points are salient (Conroy, 2003). 19. View IP as an interpretation of participants' interpretation (Conroy, 2003). 20. Look beyond the participant's actions, events, and behaviour to a larger background context and its relationship to individual events (Conroy, 2003 citing Addison, 1992).
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Figure 21: The hermeneutic principles for research (Adapted from Conroy, 2003, p. 11) (CC-BY Creative Commons Licence)

3.2.3.4.3.4 Overarching Questions to Develop Commentary

This section outlines Conroy’s (2003) Hermeneutical Development of Commentary (HDC), which assists researchers to ‘appraise one’s interpretation’ (Conroy, 2003, p. 26) (see Figure 22).

<p>Hermeneutical Development of Commentary (Adapted from Conroy, 2003)</p> <ul style="list-style-type: none"> • Commentary can be used during interview • Commentary can be used during analysis • Commentary can be used for either interview or analysis • New additions to Conroy's (2003) Hermeneutical Commentary.
<ol style="list-style-type: none"> 1. What is being said ‘on the face’ of their words - participants and researcher? (Precis form – putting their and my words into words) 2. What is the line of thought – within a segment and across segments of participants’ words within one session? 3. What is lying beneath the ‘face value’? What is the text showing? (Heidegger’s Modes of Engagement and Modes of Existence) What significant factors turn participants away or toward another mode of existence? 4. What am I missing (explicitly or implicitly said)? What is so ‘normal to me’ that I can’t see it? 5. Why is this topic being presented – to me? –at all? 6. What is causing anxiety to the participant? What is the significance to the participant of this articulated event? 7. Why am I asking the questions I am asking? What typed of questions am I using according to communication/interviewing theory? Am I helping of hindering the flow of the story telling? 8. Am I listening/responding within the participant’s world or from a world outside her own? ie. From mine? How synchronised am I with what the participant is saying? 9. What learning is not happening here? 10. What is the nature of the situation? 11. What is the historical nature of the experience to the participant? (Heidegger – temporality) 12. Is there an apparent mood to the interview exhibited by the participant? What are his emotions? 13. What is valued by the participant? 14. What are her concerns/issues? What is her body language telling me? (Reflections/notes made immediately after the session) 15. What themes are running through the conversation? 16. Are there similar events talked about within the conversation or within other conversations with the same participant? <p>When listening to tapes I noted the tone of voice, silences, pacing and balance of conversations as contributing to ‘mood’, where moods are open to the public and stem from cultural sensitivity. Notes: bolding of text denotes some degree of voice emphasis as is being said ‘on the face’ of their words – participants and researcher? (Precis Form – Putting their and my words into my words). What is the ‘Line – of – thought’ - within a segment and across segments of participants’ words within one session? Does the precis show where the thought and meanings across segments answer the questions related to the research question?</p>

Figure 22: The hermeneutical development of commentary (Adapted from Conroy, 2003, p.26) (CC-BY Creative Commons Licence)

It was considered ‘a double tape in one’s head’ (Conroy, 2003, p. 23) where what was previously said and what was currently being said were linked. This double tape may exhibit as a simple question. The researcher may ask the first question of the HDC, ‘What is being said “on the face” of their words—participants and researcher?’ (Conroy, 2003, p. 24).

The commentaries were adapted to direct my focus before, during and after the collection and analysis of the data. Questions asked before the interview are coloured green in Figure 22; those asked during the interviewing and analysing of data are in orange; while questions in black were asked after the interview. Although the commentary was used in this manner, other variations are possible. Further adaptations occurred during the analysis of data; coloured red in Figure 22 and explained in the methods section. The operationalisation of the commentary in this study is covered in more detail in the methods section with supportive evidence from memos, précis sheets and transcribed interviews.

3.2 Methods

The purpose of this section is to describe the processes used to gather, analyse, interpret, store and manage the data (Speziale & Carpenter, 2007). Conroy (2003, p. 5) identified this process as a collection of ‘footprints’ for the inquiry: ‘Metaphorically I used “footprints” to refer to an individual’s contribution to the hermeneutical spiral. In the research process, as in life itself, many footprints join through interpretation to create a new pattern of understanding’.

An individual’s contribution might leave a footprint that shows they had conducted an interview, or had reviewed narratives or had reflected on a situation. These ‘footprints’ describe who contributed to the inquiry and the ‘pathway’ describes the methods used to manage the inquiry (Conroy, 2003). Analysis of the data was initially portrayed by Heidegger (1926) as the hermeneutical circle—a process to describe the researcher’s and others’ involvement in the inquiry.

Parsons (2010) pointed out that the hermeneutical circle of inquiry recognises the practical engagement of everyday life, where old understandings of individual parts gives way to new understandings. Ajjawi and Higgs (2007) described this circle as the

researcher's engagement with the text. Speziale and Carpenter (2007) indicated this circular process of understanding was not closed but was a spiralling process. As interpretations and reinterpretations occur in a spiralling process between the researcher, participants and others, researchers build upon their understanding by refining, questioning and interpreting meanings about a phenomenon. This spiral of understanding in Figure 23 shows the six aspects of Conroy's 'footprint pathway' (Conroy, 2003) which will be explained in detail in the 'footprint pathway'.

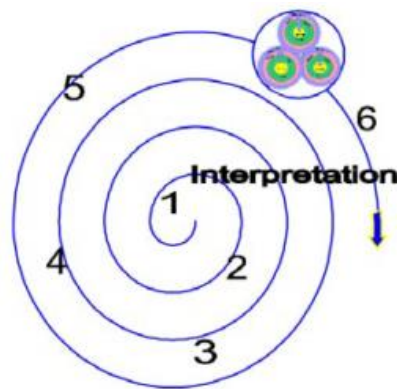


Figure 23: The hermeneutical spiral (Conroy, 2003, p. 17) (CC-BY Creative Commons Licence)

The six aspects of the 'footprint pathway' are:

- Aspect 1: attending to footprints and concurrent preliminary interpretation
- Aspect 2: in-depth interpretation
- Aspect 3: second readers, pertinent others and the greater community
- Aspect 4: paradigm shift identification
- Aspect 5: exemplar development
- Aspect 6: principle development.

The six aspects of Conroy's (2003) footprint pathway are illustrated in text as a linear progression, but in reality they are not fixed in time or place (Conroy, 2003) (see Figure 24).

The Footprint Pathway					
Aspect 1 Attending to footprints & concurrent interpretation	Aspect 2 In-depth interpretations	Aspect 3 Second readers and participants	Aspect 4 Paradigm shifts	Aspect 5 Exemplar development	Aspect 6 Principle development

Figure 24: The footprint aspects (Adapted from Conroy, Table 2, p. 19) (CC-BY Creative Commons Licence)

The footprint pathway outlines and illustrates how the data in the current study were collected, analysed and managed using the hermeneutic approach. This interpretative process is one that interweaves or connects with other individuals and entities to acquire new knowledge or insights about experiences. This section also outlines how rigour was assured. The first footprint to be described is Aspect 1: Attending to footprints and concurrent interpretations.

3.2.1 Aspect 1: Attending to Footprints and Concurrent Interpretations

The first part of the pathway describes how the interpretation and understanding of the phenomenon occurred through all stages of the inquiry. Aspect 1 outlines how hermeneutical principles and commentary are operationalised and guide the collection and analysis of data. Speziale and Carpenter (2007) indicated that the design of an inquiry should incorporate elements such as the participant information, interview setting, interview rules, piloting the instrument and managing data. The various components of Aspect 1 were ‘sourcing footprints’, ‘collection strategies’, ‘interview strategies’, ‘attending to raw data’, ‘concurrent analysis of footprints’ and ‘reflexive accounts’. The range of footprints collected is described in a linear relationship. However, the broken lines throughout the range of figures in the footprint pathway indicate that movement occurred between all aspects of the footprint sources and was not always linear. This movement is described in each aspect of the footprint (Conroy, 2003). Figure 25 illustrates the connections between strategies used in Aspect 1.

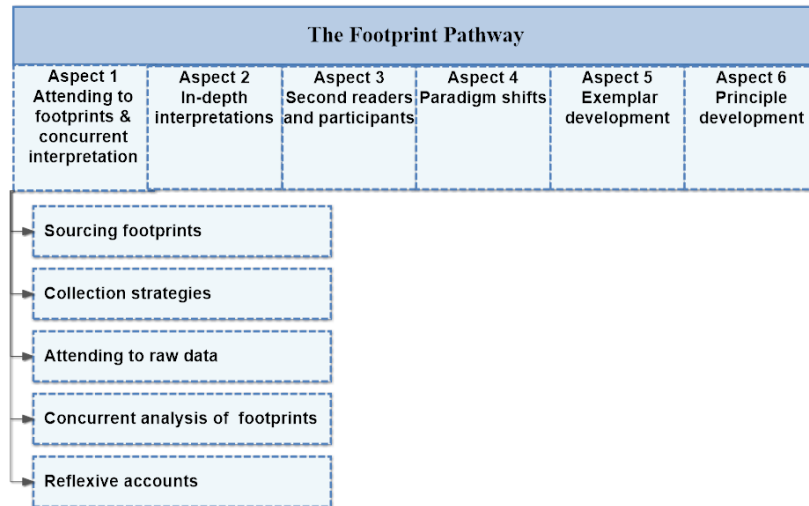


Figure 25: The footprint—Aspect 1

3.2.1.1 Sourcing Footprints

Sourcing footprints describes the sources of information; how individuals were selected and recruited to the study. Figure 26 illustrates where the setting, the selection and the recruitment of participants occurred in the footprint pathway.

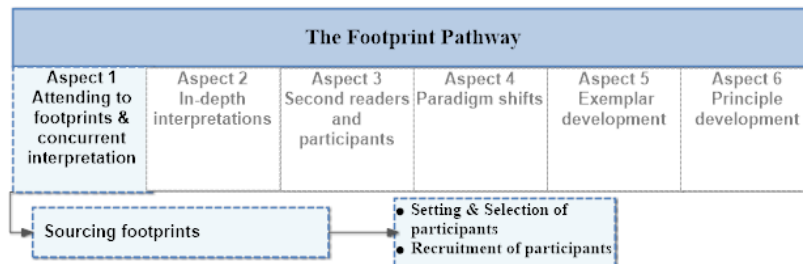


Figure 26: Sourcing footprints

The sources of footprints were obtained from my reflexive notes, second readers’ and others’ information, and were managed through interviews, digital recordings, transcripts, feedback from participants, second readers and participants, from relevant documentation and from reflexive notes (see Figure 27).

Footprint Sources					
<p>Interviews</p> <ul style="list-style-type: none"> ● Interview schedule ● Self Interview ● first interview ● Second interview ● Collection of demographic information ● Direct observation notes abandoned 	<p>Digital recordings</p> <ul style="list-style-type: none"> ● Digital recordings captured ● Double recordings occurred after the fifth interview ● Second Interviews were doubly digitally recorded ● Digital recordings were listened to several times ● Digital recordings captured participants consent, the researchers overview and at a later interview, the emerging themes. 	<p>Transcripts</p> <p>Researcher</p> <ul style="list-style-type: none"> ● Verbatim transcription of self-interview. <p>Participants</p> <ul style="list-style-type: none"> ● Verbatim transcription of first interviews ● 2nd interview transcriptions <p>Interpretation worksheets for second readers</p> <ul style="list-style-type: none"> ● Transcribed into Excel ● Guiding questions indicated <p>Interpretation worksheets compiled</p> <ul style="list-style-type: none"> ● Initial coding of individual cases were collated ● Precise sheet utilized by researcher ● Another precise sheet utilized by second readers 	<p>Feedback</p> <p>Second Readers Feedback</p> <ul style="list-style-type: none"> ● Selected transcripts were sent to second readers. <p>Participant Feedback</p> <ul style="list-style-type: none"> ● Initial themes developed from this feedback ● Overview of themes was sent back to participants for verification of truthfulness. ● Second interview captured feedback 	<p>Documents & other sources</p> <ul style="list-style-type: none"> ● NCAS - The National Competency Assessment Schedule ● ANMC Standards - Australian Nursing & Midwifery ● Conroy's (2003) Hermeneutical Principles of Research ● Conroy's (2003) Hermeneutical Commentary ● Conroy's (2003) Heidegger's Three (unsettled) modes of existing or taking a stand ● Facilitation Report 2008-2011 ● Facilitation meeting overview for second readers. ● Other support 	<p>Reflexive notes</p> <p>Ongoing Evernote diary:</p> <ul style="list-style-type: none"> ● Self interview reports ● Pre and Post interview field notes were captured in Evernote diary ● IPA Memo - Decisional trail ● NVivo Memo ● Second Interview Memo ● Second Readers Memo ● Framework Development Memo ● Collation of useful documents ● Pre and Post interview field notes were captured in Evernote diary

Figure 27: The footprint sources (Adapted from Conroy, Table 3, p. 22) (CC-BY Creative Commons Licence)

3.2.1.1.1 Setting and Selection of Participants

For this inquiry, the selection of CFs occurred in WA. The participants were purposively selected from a population of nurses living in the metropolitan area of Perth, as the highest number of CFs in WA came from this geographical area. A homogenous sample is necessary when researchers aim to describe in detail the experiences of a particular group of individuals (Patton, 1999; Speziale & Carpenter, 2007). Homogeneity occurred in this study because of the specific role of the CF, being employed by a HEP to support final placed students, and when nurses dealt with a variety of health settings, relationships and resources. Although experience in clinical facilitation was desirable, a novice CF would provide additional insight as they had not become enculturated in workplace behaviours.

The approach used was nonprobability sampling (Russell & Gregory, 2003). Nonprobability selection methods can be applied in a variety of ways such as purposive, expert and snowballing sampling (Etikan & Bala, 2017). In purposive sampling the researcher uses their judgement to determine who will provide the best information. The benefit of using purposive sampling is that it allows rich data to emerge (Russell & Gregory, 2003; Ryan, Coughlan, & Cronin, 2007). However, Sharma (2017) reported that purposive sampling can be prone to researcher bias unless clear criteria, theoretical frameworks or expert elicitation are utilised. In expert sampling, the population chosen would have specific experience related to the phenomenon. The researcher may use a snowballing approach when they have little contact with individuals or organisations (Grbich, 1999) or if these are difficult to access (Sharma, 2017). However, this method could prevent other individuals from participating in the inquiry (Speziale & Carpenter, 2007) and should not be considered to provide a representative sample of the population (Sharma, 2017).

In this study, selection occurred through purposive sampling where both novice and expert facilitators were initially invited to participate. The population specific to this study were RNs who specialised in facilitating nursing students on a final placement. In addition to this approach, a snowballing approach was utilised so that individuals who had been approached via email or telephone could forward information about the study to their colleagues.

HPR #1, 19 and 20 (Figure 21) apply to these steps of sourcing information, as the intent was to actively engage in dialogue with nurses who had specific experiences dealing with final placement students. Without these experiences, the dialogue would not answer the research questions. The next section, on collection strategies, describes how participants were recruited.

3.2.1.1.2 Recruitment of Participants

A small sample of 8–12 registered CFs employed by Western Australian universities was asked to participate in the study. The use of a small number of participants for a qualitative inquiry is generally sufficient to collect in-depth information (Polit and Beck, 2008; Ryan et al., 2007; Smith and Osborn, 2007). Russell and Gregory (2003) considered that large sample sizes would focus more narrowly on a phenomenon, whereas having a smaller number of participants would broaden the meanings about a phenomenon.

A small sample of experienced CFs known to me was chosen because I had their contact numbers to commence the snowballing approach. The snowballing approach then opened up the opportunity for other participants to become part of the inquiry (HPR #11, 14). In this way, the process of fairness was ensured.

The individual CFs were contacted by phone or email. The participant information sheet (Appendix B) was used by the researcher to briefly outline the purpose of the study. All CFs received a plain language statement (Appendix C) along with the consent and demographic information so that they could understand specific information about the conduction of the inquiry. The plain language statement outlined the details of the inquiry, along with the importance of their contribution, the time required for first or follow-up interviews, the risks and benefits of participating, the right to withdraw at any time and details about the intended publication of the findings. They were also provided with my contact details so that they could contact me or my supervisors, to address any concerns they had about the inquiry or me as the researcher (HPR #4). Participants who accepted this offer were recruited into the study. All participants were requested to forward the inquiry on to other CFs who were interested.

I had previously worked with some participants but not been in contact with them for at least 2 years before the inquiry. No coercion or pressure was used with participants (HPR #2, 4, 11). Careful consideration of the ethical aspects of establishing rapport, having fairness, being respectful and being mindful about not doing harm to participants was carefully considered before and after receiving approvals from the School of Nursing and Midwifery Research Committee and the Human Research Ethics Committee (HREC) at the University of Notre Dame University, Fremantle. (Appendix D), in the plain language statement (Appendix C) and throughout the process of the inquiry (Australian Government National Health and Medical Research Council, 2007).

In addition to participants for in-depth interviews, other individuals were significant to this inquiry. These were academic supervisors, second readers and other CFs who could assist with clarifying the participants' emerging interpretations. Supervisors were significant as they questioned interpretations and reviewed parts of the raw data as they emerged. The second readers, participants and wider community of CFs added further clarification and interpretation about the meanings (HPR #18).

To source second readers and other CFs an invitation was sent to nursing colleagues to be either a second reader or to confirm the final interpretations of the phenomenon. RNs attending an informal meeting were invited to become second readers; however, no one volunteered. My two supervisors became the second readers; through seeking further clarification about my interpretations and reading selections of the narratives, they could confirm my findings. In addition to second readers, other CFs were telephoned or emailed to participate in further clarifying the framework based on their experiences (HPR #6, 9, 10, 20). How I had worked alongside participants and second readers is described in the next sections, on collecting data and attending to raw data, and is further expanded on in Aspect 3.

3.2.1.2 Collection Strategies

Vandermause and Fleming (2011) identified that when collecting data, researchers should ensure that the interview strategy can collect relevant data required by the interviewer. Speziale and Carpenter (2007) added that an interview schedule should outline how the conversation would be guided, and cover aspects such as determining

the research questions and the interview process. In addition, I needed to consider the best place to conduct the interview and what equipment would be needed to record and take field notes (HPR #5). Strategies used throughout the collection of data are explained in Figure 28. Guiding questions, interview settings and interview strategies were established with participants.

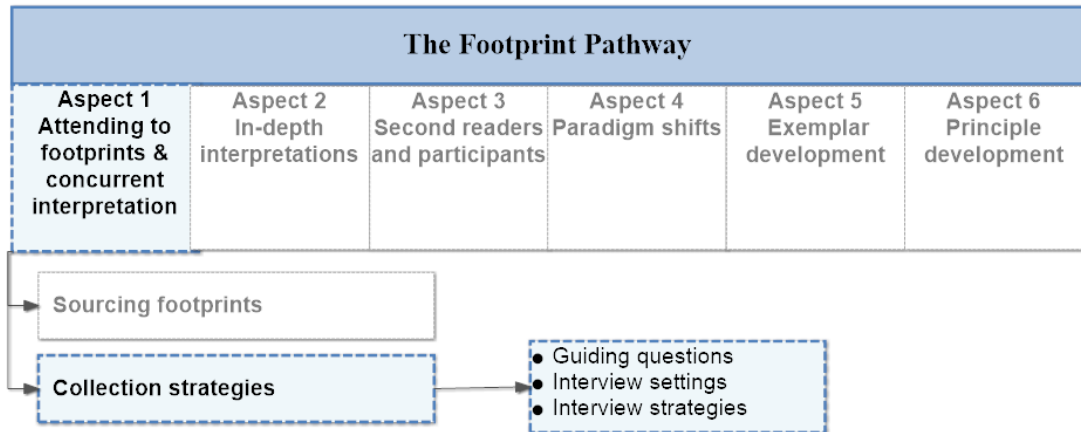


Figure 28: Collection strategies

3.2.1.2.1 Guiding Questions

Brink and Wood (1988) explained how they approached the collection of data: ‘Level 1 studies take place in natural settings to describe what exists, as it exists. Answers to these questions provide a complete description of the topic’ (p. 11). When more is known about the topic a second level of questioning occurs. This requires more knowledge about how the variables may affect individuals. In exploratory designs, the use of questions needs to be open ended and flexible to establish the relationships among variables (Brink & Wood, 1988).

The two questions asked were:

1. What were CFs’ perceptions of the factors that affected the final-semester nursing student’s ability to be ready for the role of the RN?
2. How did CFs I, A & M these factors?

Smith and Osborn (2007) and Vandermause and Fleming (2011) considered that a semi-structured interview gives the researcher the flexibility to expand on and explore participants’ experiences and meanings. Guiding questions assist participants to open up and provide more in-depth information (Smith et al., 2009). For this inquiry,

although guided questions were used during the interview process my focus was on building rapport and establishing participants' concerns rather than focussing solely on a set of ordered questions. According to Heidegger's hermeneutical principles, the researcher's receptivity to the participants' experiences occurs through immersion, dialogue and being reflexive (HPR #3, 6, 10). I viewed every account as related to a participant's background and as being significant to the participant (HPR #11, 12, 13).

To construct the interview schedule, Smith and Osborn (2007) asked researchers to think explicitly about what questions would elicit data relevant to the lived experience. Such questions might relate to behaviours, feelings, knowledge or opinion. Turner (2010) recommended that researchers avoid using the 'why question' and Grbich (1999) explained that 'why' questions stifle participants' responses during interviews and should be used only after careful consideration.

Smith and Osborn (2007) suggested that researchers begin with the most general questions and work towards more specific ones. Patton (1987) provided a framework for when it was best to use certain types of questions. This framework identified questions in the order of the participant's behaviour or experience, their opinion or beliefs, feelings, knowledge, sensory information and demographic information.

Five guiding questions were developed for this inquiry so that it would capture the participants' experiences, how they were affected and how they had coped (Appendix E). These questions were shortened, modified and added to as required to explore participants' experiences:

1. Can you share with me a situation where a student struggled?
2. What factors have you identified that adversely impact upon student progression?
3. What are the barriers and enablers for identifying, assessing and managing these risks?
4. How have these factors impacted you in identifying, assessing and managing your students?
5. Can you tell me how these factors have impacted on your relationship with students or the clinical placement staff?

In this inquiry, a more general strategy was to ask participants about their opinions and experiences before asking more personal questions related to their feelings and how these experiences had affected them (HDC #7). Demographic information (Appendix F) was collected at the end of the interview as recommended by Patton (2015). The demographic questions in this inquiry describe the attributes of the population sampled, and are covered in Chapter 4.

Turner (2010) and Burns and Grove (1993) articulated that researchers who are familiar with the activities of participants might conduct a pilot test to refine the research questions. Testing identifies if the interview questions assist with the flow of information, if there are flaws associated with the interview questions and if the time needed to conduct the interview is sufficient to obtain responses related to the questions.

Grbich (1999) indicated that it was unusual to pre-test tools in qualitative research. In contrast to this view, Turner (2010) considered a pilot interview or test would identify the weakness of the interview design. In this study a pilot interview was undertaken. The survey questions were practised on a RN who had experience in facilitating final-year students. This interview was not recorded or transcribed but confirmed that the guiding questions were suitable to elicit information relevant to the research questions (HDC #4, 7, 8, 12). It also showed that the interview technique was adequate to allow the participants to disclose their experiences about the phenomenon, and increased my confidence in seeking out the participants' stories.

3.2.1.2.2 Interview Settings

Two opportunities to undertake in-depth interviews in a naturalistic setting were offered to participants. A naturalistic setting makes the participant feel comfortable or familiar in the environment (Pope & Mays, 1995; Turner, 2010). It is an environment that does not make an individual feel constrained (Turner, 2010; Vandermause & Fleming, 2011). A date, time and place are selected that are mutually satisfying to both the interviewer and the participant (Vandermause & Fleming, 2011) (HPR #6). In this study, the interviews took place in an office, library rooms, individual homes and a coffee shop.

For a second interview, participants were offered the choice of a face-to-face interview or a telephone interview to clarify the emerging themes and provide further information related to the phenomenon. Turner (2010) recognised the benefits of collaborating with others to clarify and confirm the emerging findings, as the process helps remove bias and over-analysis. Rapport was essential in this study to explore the experiences. The use of questioning techniques was also necessary when interviewing participants to encourage them to tell their stories.

3.2.1.3 Interview Strategies

Before conducting an interview with a participant several strategies were considered to improve the interview process. Walker (2011) reflected on the dilemma that can arise when researchers do not know their boundaries and recommended that researchers consider how they will interact during the exchange of information. Although Walker suggested that sharing stories could be beneficial, I avoided talking about my own personal experiences to ensure a focus on the participant's story. To encourage participants to open up about their experiences, rapport was developed and questioning techniques were used (Shenton, 2004).

3.2.1.3.1 Establishing Rapport

Smith et al. (2009) reported that to gather reliable data, interviewers should develop a rapport with participants. This means that interviewers should seek to understand, to draw out and enter active dialogue with participants (HPR #1, 5). To establish rapport, effective communication with participants before and during interviews is required (Smith et al., 2009; Vandermause & Fleming, 2011). Increased rapport, trust and empathy is achieved through 'visual, auditory and kinaesthetic ways of communicating' (Conroy, 2003, p. 26). Vandermause and Fleming (2011) reported that it is the researcher's tone and use of questions that influence the interview. Other ways include using small talk, which allays any participant concerns (Smith et al., 2009). Smith et al. (2009) considered that rapport is further developed when participants know that it is acceptable for them to take their time during the interview to think or talk about their experience.

Establishing rapport in this inquiry commenced from the initial greeting, through using frequent eye contact and a friendly tone, and shaking the participant's hand upon

greeting and departure. When interviews were conducted in the participant's home, I accepted invitations for a cup of tea or coffee. In all interviews, general conversations occurred until participants were ready to proceed. Going over the inquiry and explaining the role of the researcher allowed the interviewee to relax for the interviewer to establish rapport and remove concerns.

The plain language statement (Appendix C) was briefly explained and the participants had the opportunity to ask further questions. They were reminded that they could withdraw at any time and were provided the opportunity to seek counselling should they become distressed. Participants were aware that there was no immediate benefit to participating in the study.

Although I anticipated there would be no benefit in participating, one participant (Debbie) volunteered that she expected to benefit as a result of reflecting on her experiences. This acknowledgement illustrated how the researcher, through listening and questioning, could assist participants to make sense of their experiences (HPR #8, 9). Participants were aware of my experience and intention to be an active listener (HPR #2, 11). They were asked to sign the consent form (Appendix G). Participants were then invited to explain how they had entered their role in clinical facilitation (HPR #20). As they appeared more relaxed, they were then asked if they felt ready to commence talking about their experiences with students on a final placement.

3.2.1.3.2 Questioning and Responding Strategies

The second strategy used during the interview was to use questioning or responding techniques to encourage the telling of participants' stories. Berry (1999, p. 2) mentioned that using a guided approach to conduct an interview allows the interviewer to be 'free to explore and probe' the participant's experience (HPR #1). Although five guiding questions (Appendix E) were used to guide the conversation, the goal was to let the participant lead the conversation and for me to use the guiding questions as probing questions to seek out meanings (HPR #7). The five guiding questions used in this inquiry initially helped with the asking of questions and in the stimulation of a participant's responses.

To commence the interview, a descriptive prompt to encourage the responses received from participants was put forward (Grbich, 1999). The prompt was, 'Tell me about

your experiences with supervising students in their final placement'. Inviting participants to tell a story helps them remember aspects that influenced them (Vandermause & Fleming, 2011). Single questions that are clear and open ended allow participants to comprehend and expand on what is being asked of them (Berry, 1999; DiCicco-Bloom & Crabtree, 2006). In this inquiry, it was not always easy to use single questions, and at times the question was repeated in a different way. As more interviews were undertaken and I became more aware (HPR #15), it was easier to ask questions that were clearer and simpler.

Interviewers can question using probing, funnelling, open-ended types of questions, sequencing of questions or prompts. Probing techniques occasionally paraphrase or echo what participants have said. Probing is useful if the interviewer does not probe too deeply into sensitive issues and make participants feel uncomfortable (Berry, 1999). However, DiCicco-Bloom and Crabtree (2006) identified that participants who had not shared their emotional stories felt relief that they were finally able to share their stories with the researcher.

In using Berry's (1999) and DiCicco-Bloom and Crabtree's (2006) recommendation to probe, statements were used to seek further information; for example, 'So if you could help them, how would you help them?'. This question explored what may have lain beneath participants' comments, what they valued and how they may turn towards or away from authenticity (HDC #3, 13). Smith and Osborn (2007) suggested using the technique of funnelling. This technique uses generalised questions before asking more in-depth questions.

Berry's (1999) additional strategy for interviews was to first ask about the behaviour or experience before opinions or feelings were sought. During the interviews this method was used to move from the general to the more specific; for example, 'So, can you tell me how this impacts you?'. Funnelling also requires clarifying statements such as, 'So, I think what you are saying is...' and affirming sounds such as 'Mm, mm' or 'Ah ha' to show engagement or understanding about what is being said. By using these techniques, the interviewer ensures they are working with the participant to assess which points are salient and to see the world from the participant's perspective (HDC #7, 10, & 14).

Some open-ended questions asked were ‘Can you explain that for me?’ and ‘What does that mean to you?’. This technique of questioning encouraged participants to clarify what they meant. At times participants were silent for short periods but were not interrupted so that they had time to think about their answers. Smith and Osborn (2007) suggested that all participants need is a ‘gentle nudge’. At all times the intention of the interviewer should be to use phrases or prompting in a manner that does not lead the participant, as this may affect the credibility and trustworthiness of the inquiry (Walker, 2011).

Berry (1999) suggested that interviewers sequence their questions and maintain control of the process at the same time as giving the participants free rein in what they say. Vandermause and Flemmng (2011) also suggested that interviewers could utilise incomplete sentences to clarify a point or encourage the participant to return to the story they were telling. Grove et al. (2012) added that interviewers should obtain information sensitively, so that participants do not feel as though they are being grilled.

Vandermause and Fleming (2011, p. 373) considered that the researcher is ‘bound to assess the response’ and via gentle suggestions can stimulate the participant to clarify or correct an incorrect assumption. In this study my prompts and the participants’ responses were examined to ensure that the voice of the participant was heard. The HDC questions reflected on were #7 & 8: ‘What type of questions am I using’, ‘Am I helping or hindering the flow of the story telling?’ and ‘Am I listening/responding within the participant’s world or from the world outside her own?’. As ethical behaviour and rigour are key aspects of a quality inquiry, focus was maintained on participants’ stories.

These sections have described the sourcing and collecting of footprints. The next section describes the capture and management of data. These processes were manual, digital and computerised processes for managing field notes, digital recordings, transcripts and demographic information.

3.2.1.4 Attending to Raw Data

Primary data were collected by interviewing participants. These included the field notes, digital recordings, transcripts of the digital recording and collection of demographic information. Vandermause and Fleming (2011) suggested that field

notes and demographic information are a way to extend the analysis. Conroy’s interpretative pathway of attending to raw data has been compared with Ajjawi and Higgs’s (2007) stages one and two: ‘immersion’ and ‘understanding’.

‘Immersion’ is described as involving re-reading texts, organising transcripts and attending to preliminary interpretation. ‘Understanding’ occurs when first order constructs are made and placed in NVivo (Ajjawi & Higgs, 2007). In this study, the transcripts were listened to several times to transcribe the data as was stated, capture the tones, re-read and re-check the raw data, identify first order constructs and ‘keep track of movements’ (HPR #17). The attendance of data occurred through field notes, digital recordings, transcripts and demographic information (see Figure 29).

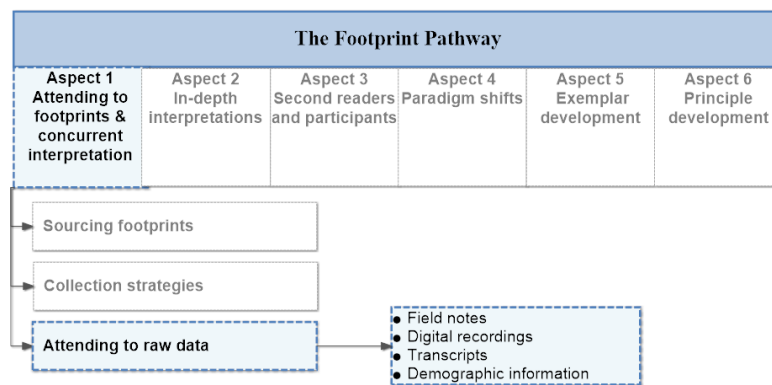


Figure 29: Attending to raw data

Field notes that were taken throughout the inquiry are described below.

3.2.1.4.1 Field Notes

Grbich (1999) outlined specific ways to capture field notes and other recordings. Field notes can be jottings and notes written before, during or after an interview. These can be observations that can include facial expressions, body positioning or assumptions that are being made by the participant or researcher (Speziale & Carpenter, 2007). Vandermause and Fleming (2011) reported that field notes capture natural signs such as ‘vocal intonations and physical gestures’ (p. 370). However, not all experts agree on the value of taking field notes during an interview. Wheeler (2011) did not write field notes during her interviews. Wheeler (2011), Grbich (1999) and Turner (2010) considered that this shifts the participant’s focus away from the story and researchers need to carefully consider the need to write notes during the interview.

In the pre-planning stage of the inquiry, although field notes were expected to be captured by taking notes during the interview, taking field notes was abandoned during the first interview. The participant appeared distracted by the initial jotting down of observations and this was seen to alter the flow of communication. Thus in this inquiry the field notes and other reflections about the interview were recorded before and after interviews in an Evernote (Evernote Corporation, 2015) diary or on a digital voice recorder. The Evernote diary could capture information and show evidence of reflection.

Abandoning the field notes ensured a more relaxed approach and more immersion in what the participant was saying. There was also a greater reliance on the digital recordings to recognise and reflect on the moods and actions of participants. Grbich (1999) recommended that observations be captured within 12 hours of the interview to minimise errors. This was achieved through writing up field notes immediately after the interview and speaking into the recorder about the experience.

In this inquiry, writing field notes after the interview was used to record moods, values and interviewees' body language. Types of distress were recorded across all participants' narratives (HDC #16). Participants who had shown strong emotions were given the opportunity to stop the interview but all wanted to continue. The collation of observations in Figure 30 demonstrates the options offered to participants. The reflection illustrates the synthesis of distress and the use of the HDC in reflection.

1 #8 #6 #11 #12 #13 #14 #15 #16

In some interviews, participants were momentarily impacted when they told me their stories. This was seen in the arousal of emotions, tear filled eyes, tapping on the tabletop, body position, tightening sounds of the vocal cords, or the appearance of discomfort when talking about some of their stories. In these instances where participants, (1,3,6 & 7) exhibited some signs of these emotions, participants were given the opportunity to gather their breath, or have a break, have the recorder switched off, or have the interviewing process stopped. No participant took on these options and very quickly recovered as the interview progressed.

Figure 30: Field notes linked to the hermeneutical development of commentary

The inflection of tones and the further remembrance of significant observational factors was triggered for me when digital recordings were later played back.

3.2.1.4.2 Digital Recordings

Digital audio recordings were made of the interviews. Audio recordings are part of the interview process (Grbich, 1999; Vandermause & Fleming, 2011) and capture the dialogue of both the interviewer and the participants. Mero-Jaffe (2011) stated that the ‘intonation, emphasis, voice volume, changes in voice patterns and body language’ (p. 232) can be remembered and documented. As these data provided the foundation for the transcription, deeper meanings about the phenomenon emerged through transcribing words, sighs and expressions as they had occurred.

Turner (2010) reiterated that where guiding questions can be modified, data will be thick with descriptive detail and show the complexity of interactions and interpretations about an environment. In this study the audio captured nuances of distress or anxiety as well as the narrative. Actions such as ‘a nervous laugh’ and the participant ‘glancing down at the recorder’ were remembered on listening to a recording.

According to Mero-Jaffe (2011), improperly functioning equipment may interfere with the overall quality of an inquiry. To increase confidence in how the data were collected and managed, the recorder was prepared and tested before each interview commenced. The selected recorder had a date and time stamp function and a microphone sensitivity function, and could record for up to 260 hours.

Walker (2011) referred to an extended time of recording as enabling the researcher to stay focussed on the participant rather than worrying about the equipment. However, for the fifth interview, the batteries had inadvertently not been replaced. Therefore, a small section of the participant’s narration was missed and was excluded. However, in the follow-up interview, this participant clarified her experience against the emerging themes and highlighted further concerns. HPR #1, 2, 3, 4, 8 were used as meanings were sought.

Grbich (1999) recommended the use of a hand towel to prevent scratches to participants’ tables, and although I did not provide this, it would have been useful to dull the tapping sounds made by a participant who had tapped their fingers on the table. At a second interview, one participant’s recording occurred in a café. Although

the recording was captured, it was more difficult to listen to because of background noise.

Before commencing with the interview, participants were made aware that I wanted to capture the evidence of providing an overview of the inquiry, and that the participant's verbal consent was obtained. Participants were reminded that they could refuse, stop or ask for the recorder to be switched off at any time. Grbich (1999) recommended giving participants control to turn off the recorder, and the participants in this study were given this opportunity. The recorder was placed off to the side so that it would not distract participants and was switched on once a participant agreed.

All participants were given reassurance about the protection and confidentiality afforded to their data, including deletion of the recordings once the study had concluded. Participants were given a participation number and pseudonym. In the transcripts, any person or health setting names were also coded with a pseudonym—HEP# or HSP#. This action was to protect the confidentiality of the providers.

3.2.1.4.3 Transcripts

Verbatim transcripts were produced from the digital audio recordings. Mero-Jaffe (2011) stated that the quality of transcription can be affected by the 'researcher, the interviewer, the transcriber, the participants, and the equipment and place of transcription' (p. 232). Further, researcher and participant attitudes, background influences, loudness of the voices, location of the equipment and omission or addition of salient points throughout the recording and the transcription process can influence the quality of the transcript and subsequent interpretation.

Individual digital audio files were stored on my computer and encrypted when not in use. These files were individually transcribed into a Word document using Express Scribe Pro. Both first and second interviews were captured and stored for transcription. The storage of data was maintained until the study was finalised. Transcripts and audio content will be destroyed after 5 years as per the university's requirements.

The types of communication heard were included in the transcripts: pauses, tones, laughter, body language, environmental distractions and participant demeanour. Pauses were shown using [Pause]. Bolding was used to indicate when participants

emphasised specific words. The digital recording was listened to several times to confirm the accuracy of the transcript and the inflexions of tone. Mero-Jaffe (2011) pointed out that sorting through problems related to transcribing is a significant issue as the process could alter the meanings of the phenomenon. When second readers questioned the narrative or pointed out typing errors, these sections of the interview were reviewed to ensure the meanings were correct.

3.2.1.4.4 Demographic Information

Grove et al. (2012) described demographics as being the attributes or characteristics of the sample population. Demographics are significant for evaluating and comparing findings with those for other populations (Sifers, Puddy, Warren, & Roberts, 2002). Demographics can describe social, psychological, economic, biological and environmental information about the population sampled.

In this study, distinctive characteristics such as age and gender were defined, alongside descriptive characteristics such as capacity and background of participants. The demographic data reveals their backgrounds and how they make interpretations from this about their experience (HPR #8, 11, 14, 20). Demographic questions in this inquiry did not include physical attributes of age or gender, but more specifically characteristics of capacity and background. A participant's capacity was related to their practice in facilitation, education and current clinical expertise. The participants' backgrounds were related to social, cultural and historical contexts such as their previous interactions with educational providers and HSPs, with other nurses and with nursing students. Four demographic questions were asked after completion of the interview (Appendix F):

1. Have you received training in how to supervise undergraduate nursing students?
2. How many final-semester students do you supervise in a year?
3. How many years have you been in a clinical educator role?
4. Do you work as a RN in any other capacity outside of supervising nursing students? If yes, what specialty do you work in?

The responses to the demographic questions are reported in the findings of Chapter 4.

3.2.1.5 Concurrent Analysis of Footprints

Benner (1994, p. 113) suggested that researchers begin with a first step of searching for ‘strong instances of concerns or ways of being-in-the-world’. Grove et al. (2012) relayed that reading with re-reading assists with the synthesis of the data and allows codes and theme to emerge. This aspect of analysis is one where first order constructs emerge (Ajjawi & Higgs, 2007) (see Figure 31 for the illustration of concurrent analysis of footprints).

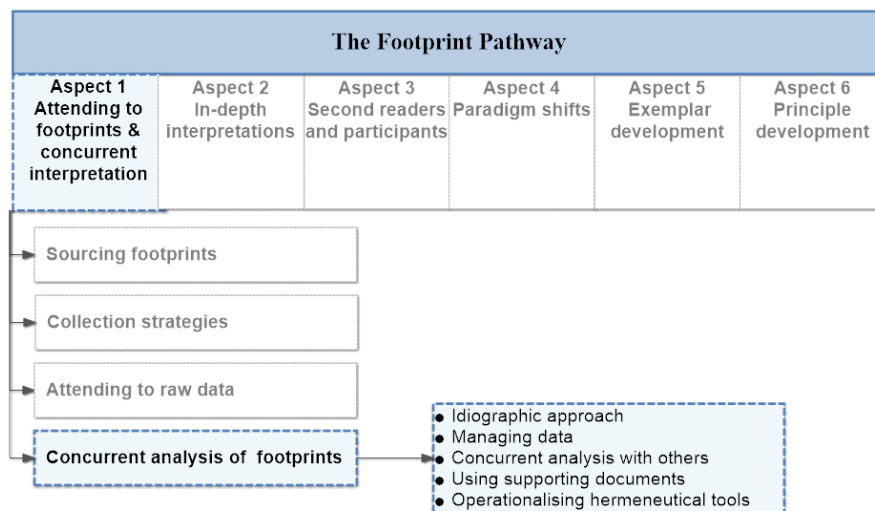


Figure 31: Concurrent analysis of footprints

3.2.1.5.1 Idiographic Approach

Smith and Osborn (1999) explained that ascertaining an individual’s meanings is best approached via an idiographic approach; where individual cases are examined and analysed in depth before moving onto the next case. This approach contrasts with Husserl’s intent of capturing the overall essences of experiences. Although commonality between participants’ meanings is sought, Pringle et al. (2011) reported that divergent and convergent meanings could be significant.

Forrester (2010) recommended that each interview must ‘be fully worked-up analysis on one case before moving onto the next case. Comparisons between cases are made later on’ (p.180). A similar process was followed in this study. The interview of each participant was recorded, transcribed and analysed before the next participant was interviewed. Both Conroy’s (2003) HPR and HDC were reflected on during the immersion and synthesis of the data.

3.2.1.5.2 Managing Data

In preparing for analysing and coding, the transcribed narratives and demographic data were copied into a worksheet. A preliminary analysis with coding was commenced using NVivo (QSR International, 2010). The first order codes that emerged showed a journey that was influenced by contextual factors. Metaphors describing these data were used to depict phenomena in the coding as a journey. However, the number of emerging codes became overwhelming and it was unclear whether guiding questions were being answered; further, NVivo (QSR International, 2010) appeared too complicated. The reflexive memo in Figure 32 shows how the decision was made to use a manual approach to coding and theming the data (HPR #17).

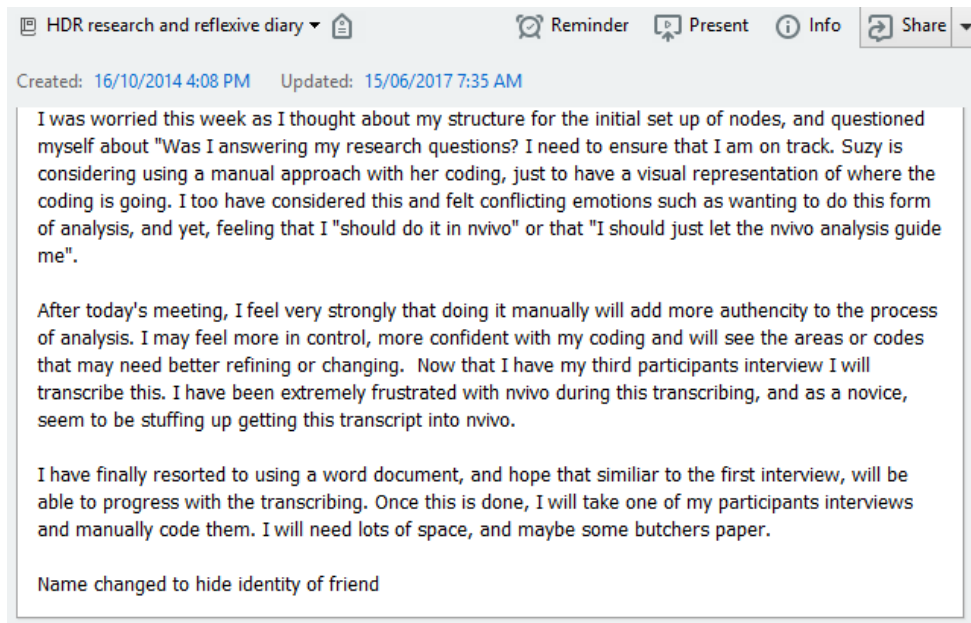


Figure 32: Decisional trails for coding

By coding in Word and then Excel documents, the five guiding questions were added in the spreadsheet (see column D in Figure 33) and this increased confidence that these narratives were addressing the guiding questions.

	A	B	C	D	E
1	Speaker	Content	Initial linking of narratives - Line - of - thought' - within a segment (HC#1)	Enabler	Barrier
75	Interviewer	So, it was just the way it fell, just that she was in that hospital.			
	Ashley 31.36	Yeah, and I think so that they get the option to have preferences. I also think that they are beginning to look at the fact that if they have, that if the hospital employs students who've been there, previously, it is seen as an advantage to the hospital to bring them back on their grad program, especially if they have been impressed.	Relationships - What does she mean here?	Q4 Understanding that students may be motivated to demonstrate employability to the HS	
76					

Figure 33: Attending to preliminary coding

The narrations were read in their entirety several times to assist with identifying important characteristics. First order constructs were placed in the Excel spreadsheet in relation to what the CF said at ‘face value’ (HDC #1) (see column C in Figure 33). The use of filtering in the Excel spreadsheets allowed all similar codes to be coloured and viewed at the same time.

This process proved invaluable as the guiding questions were seen to be answered. In this example, Q4 related to ‘How have these factors impacted you in identifying, assessing and managing your students?’ The interpretation of this section showed how the participants might use this information to motivate students. After initial codes was identified, second readers were invited to also code and review the emerging themes and the developing framework.

3.2.1.5.3 Concurrent Analysis With Others

The collection and analysis of data from a multitude of sources can occur simultaneously. In this inquiry, the process of collecting and analysing data included an initial interview from which raw data were managed and analysed. Concurrent analyses included attending to the raw data, interpreting participants’ interviews, reviewing my own and second readers’ interpretations and reviewing other documents or sources that provided a further understanding of the phenomenon. In Conroy’s (2003) approach to concurrent analysis, once an initial interview is collected and analysed, the second readers review the initial analysis made on a participant’s transcript, while the researcher begins to collect, transcribe and undertake an initial analysis of the next participant’s dialogue. Data collected from the second participant include emerging themes already created from the previous participant. Figure 34 illustrates how emerging themes occurred in collaboration with the second readers.

This occurred concurrently before I had conducted the first interview with the sixth participant.

The immersion in the data occurred to draw out what was hidden, to make explicit the findings and to dialogue with others (HPR #1, 2, 5, 6). These footprints were analysed while maintaining a constantly questioning attitude when moving between the parts and making explicit the participants' understandings by collaborating with others (HPR #7, 8, 11). In-depth analysis further occurs when supportive or clarifying documents assist the researcher to make sense of what a participant's experience may mean (Berry, 1999; Parsons, 2010). Document sources are further explained in the section relating to documents.

Participant 6

Today's interview should capture the information about one of her struggling students. I want to go into depth and find out the factors that were impeding the student from progressing. Fiona should have many stories and I expect that it has not always been easy for her to navigate students within the workplace. My codes at this stage show that fragmented relationships and hands being tied were key barriers. What I need more information about is how do students enter the workplace upon nursing registration either prepared or not prepared. Also do students fail even though they are in fact prepared. I am here to find Fiona's story. To draw out her experience and what it means to her. My findings must be kept to the side, in sight to ensure I find Fiona's experience about facilitation areas that need exploring, however it is the exploration of Fiona's experience that is central to this interview. I can come back and speak with Fiona about my findings and have confirmation in a second interview. She may add to my current findings. I am excited about this interview. I feel that I am moving forward. I have had to hire a room at a cost of \$16.00 per hour.

Figure 34: Reflection on emerging themes

3.2.1.5.4 Using Supporting Documents

Two major documents were used to aid in interpreting the narratives for identifying, assessing and managing student nurse competency. The documents were significant to the assessment of practice. The first was the *Registered Nurse Standards for Practice* (NMBA, 2006), which underpin the NCAS that HEPs used to assess student's competence. Each HEP had their own NCAS documents for a final placement. This document outlined the RN Standards all RNs needed to demonstrate.

The second document used was the University of Newcastle's resource for CFs (School of Nursing and Midwifery Faculty of Health, 2009). This outlined the clinical reasoning cycle to assess students' ability to reason, make judgements and problem solve based on the cues and observations students made about patients' situations and needs. This resource was compared with what the participants had stated about how they had identified and assessed specific nursing skills. These comparisons provided greater confidence about whether the actions of participants had matched or differed from expected behaviours currently used to assess clinical reasoning.

Hermeneutical tools also assisted with the concurrent analysis. The operationalising of these tools is demonstrated throughout the following reflexive accounts.

3.2.1.6 Reflexive Accounts

According to experts, the investigator is linked to the participant and the inquiry should capture both the participant's and researcher's perceptions for this moment in time (Conroy, 2003; Denzin & Lincoln, 1994; Polit & Beck, 2008; Reiners, 2012). To capture these perceptions, recorded evidence of the researcher's reflections should be obtained throughout the methods, theory and analysis, the phenomenon and other relevant considerations (Polit & Beck, 2008). Reflexive accounts illustrate how the HPR and the HDC are used to guide the inquiry.

In this study, reflexivity was shown through memos for insights and a decisional trail. By keeping track of thoughts and decision making in the reflexive memos, HPR #10, 14 were applied through self-reflection and recognising 'what [was] significant to the participant' (Conroy, 2003, p. 28). Figure 35 illustrates the reflexive accounts situated in the footprint pathway of this study.

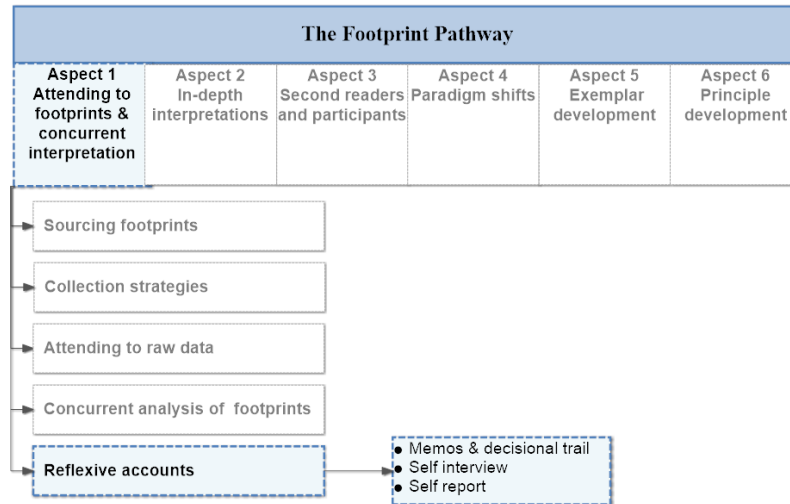


Figure 35: Reflexive accounts

3.2.1.6.1 Memos and Decisional Trail

Whitehead (2004) recommended the researcher’s reflections be used as part of a ‘decision trail’ to document the researcher’s rationale, outcome and evaluation of all actions and to document persistent engagement with the data and influences the researcher has had on the inquiry (p. 513). Forrester (2010) supported these actions and indicated this as an auditable resource that would show transparency and credibility. In this way, the rigour, integrity and competence of the researcher is enhanced (Whitehead, 2004).

In this inquiry, the memos captured how decisions were made and the instances of how decisions were made were documented in Evernote memos (Evernote Corporation, 2015). Figure 36 illustrates my reflection on determining how to manage confidential identities of the HEPs or HSPs when participants exposed who they were.

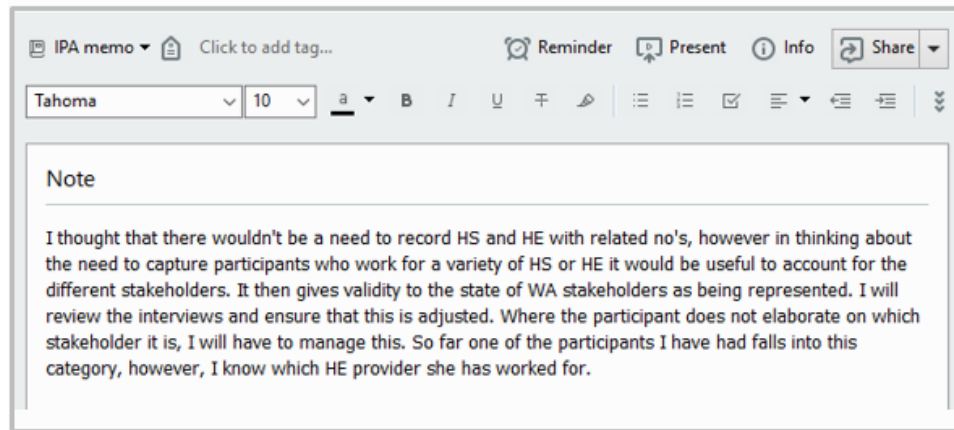


Figure 36: Reflection on managing confidentiality of participants

In addition to making notes about how decisions were made, reflexivity captured data related to documents, interviews and other insights. Before and after attending interviews, these principles were reviewed to assist with the collection and analysis of a participant's story. Sense of the participants' experiences occurred with the 'fore-having' of experience. The interviews were reflected on to consider what was different about their story from those of other participants, or my experiences (see Figure 37).

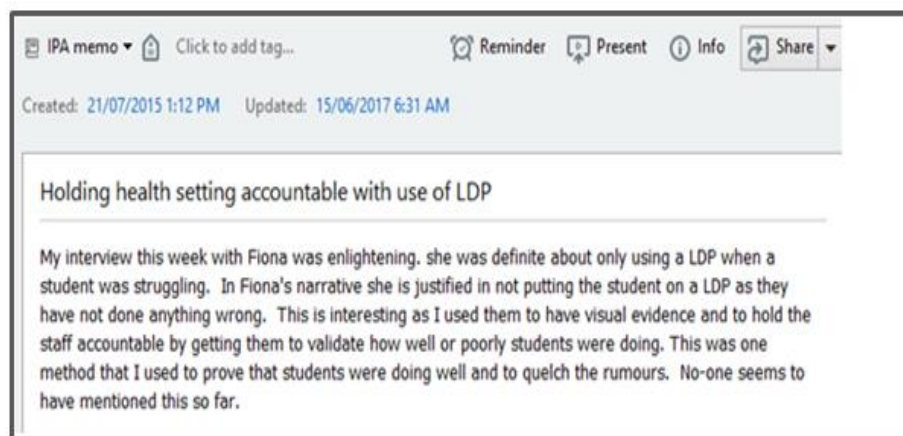


Figure 37: Reflection about differing fore-conceptions

'Foresight' was also used. Through reflexivity, I had established that participants varied in their understanding and practice. However, Whitehead (2004) stated that the extraction of hermeneutical principles may leave 'the researcher open to criticism', as this 'process of translating philosophy into practice involves the researcher's interpretations' (p. 518). However, as long as principles are compiled and set out 'in a way that is accessible and open to scrutiny' (p. 517) readers will see how the decisions were made.

Careful reflection on the commentary before and during the interviewing of participants allowed the interpretation to focus on participants' experiences and to be actively engaged through listening (Conroy, 2003). In this study, the operationalisation of the commentary commenced before data were collected. The memos describe how the HDC (Figure 22) was used. Although not exhaustive, Figure 38 is an example of how HDC #2, 3 & 7 were reflected on at times and how they were essential to refine the process of interviewing and attending to participant information.

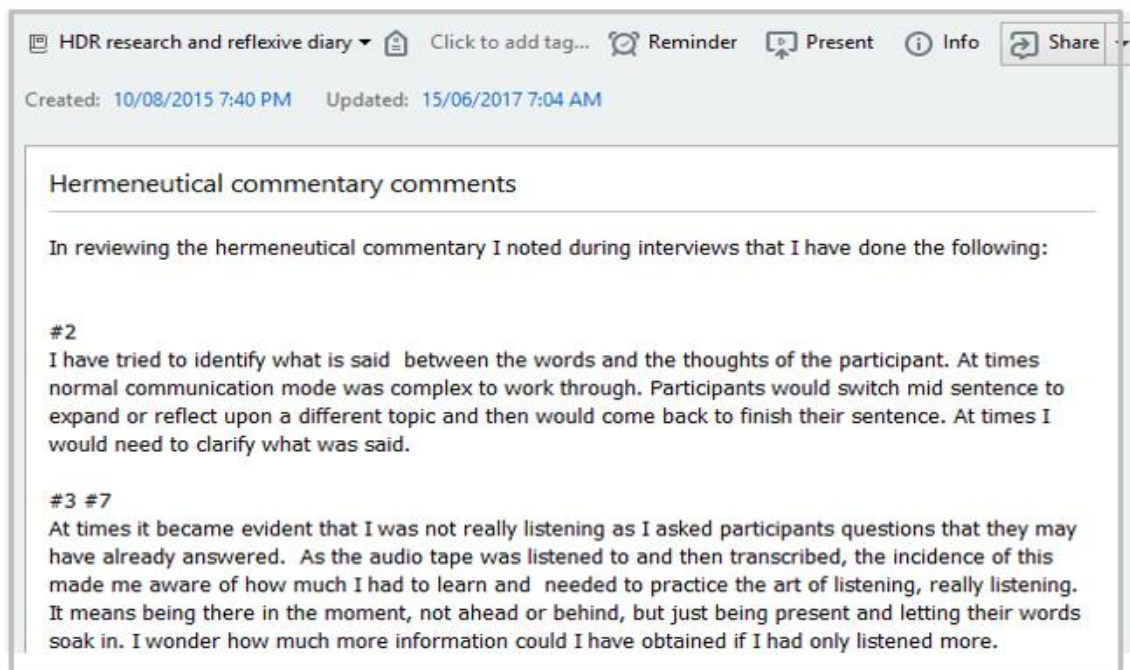


Figure 38: Reflection on using the hermeneutical development of commentary

This extract illustrates reflection on the application of the HDC to an interview after completion. Reflection on the commentary points showed that for HDC #2 the question asked was 'What is the line of thought—within a segment and across segments of participant's word within one session?' Although HDC #2 is best used for written text, I had questioned what lay behind the words the participant was using, particularly when it was disjointed or skipped back and forth between events. When the stories were disjointed, further clarification was necessary. In the above illustration for HDC #7 the questions I asked myself were, 'Why am I asking the questions I am asking?' and 'Am I helping or hindering the flow of the communication?'. By reflecting on these questions, I was reminded that as the researcher I had a responsibility to assist the participant in telling their story.

3.2.1.6.2 Self-interview

Guba and Lincoln (1994) identified that the world view, or the basic beliefs a person has about their world is how to view what is the nature of the world. To lay bare or to open up the researcher's assumptions or beliefs about this world is to 'make explicit the shared world of understanding between the researcher and the researched' (HPR #2). The researcher looks for alternate ways of seeing the world (HPR #7).

Before the inquiry commenced, a self-interview was conducted and not set aside to make explicit my assumptions about the phenomenon. The self-interview used the five guiding questions for this inquiry. However, the self-interview had been conducted 18 months after I had worked as a clinical practice facilitator. The findings revealed assumptions made about the phenomenon and although they were not collated or separated into themes, they identified a previous way of being with the experience of clinical facilitation.

3.2.1.6.3 Self-report

As the researcher, I was conscious of distorting what I had experienced and decided to rely upon a written report as evidence of my assumptions and conclusions about my experiences. Previously, I had been employed by one of the HEPs in Perth as a full-time facilitator, particularly for final-semester nursing students around the Perth metropolitan area. At the end of the period in this role, I had produced a facilitation report covering the period 2008–11. I reflected on this using the guiding questions for this inquiry. This unpublished report identified issues perceived to compromise nursing student learning within their last placement for clinical practice. This review revealed the factors I identified and supported the assumptions made in the self-interview (HPR #4, 14). Although not collated or themed, factors were identified that had been perceived to compromise student praxis and facilitator support. As I had addressed my assumptions, it felt easier to become fully immersed in the in-depth interpretation of my participants' experiences (HPR #19).

3.2.2 Aspect 2: In-depth Interpretation

The first aspect of attending to footprints and concurrent interpretations has been described. Aspect 2 describes the process of in-depth interpretation. Conroy's (20013)

Aspect 2 is to drill down deeper into the analysis to further refine the interpretations. In this inquiry, in-depth interpretation incorporated the process of seeking deeper meaning about the phenomenon where themes emerged and where variances between the meanings were recognised. To illustrate how deeper meanings were made, the ‘preparation of worksheets with researchers’ précis’ and ‘developing themes’ (see Figure 39) are now outlined.

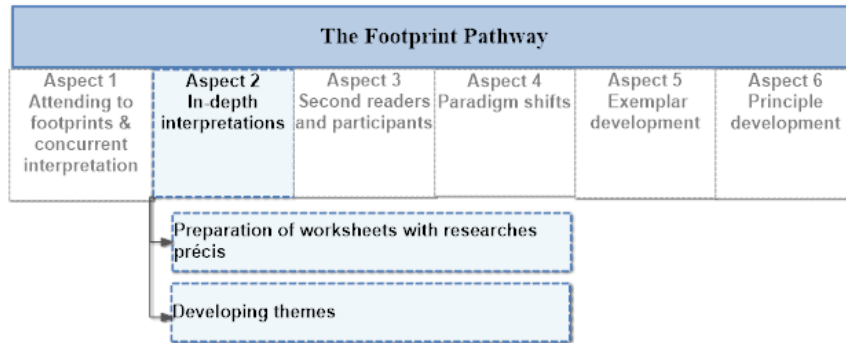


Figure 39: Aspect 2—In-depth interpretation

3.2.2.1 Preparation of Worksheets With Researcher Précis

Prior to the preparation of worksheets, an Excel format was used to manipulate the data into emerging codes. Data were colour coded to show initial interpretations of codes. Columns were added to indicate if the guiding questions were relevant to the narrative content. Figure 40 illustrates this colour coding.

Speaker	Content	Initial linking of narratives - Line - of - thought' - within a segment	Enabler	Barrier	Impact on facilitator
Ashley 17.29	Yeah, it, it is a drawback. Because I have to, although again, because I go into those same wards a lot, I know a lot of the staff, so I can trust, or find the person I am looking for, and then trust the feedback that their giving. And pretty quickly learn who's giving genuine feedback, or who might be giving feedback based on a prejudice or bias because the student's	Relationships - assessments/ trust/ making value judgements			Q5. Making a judgement about trustworthiness of feedback from CS's

Figure 40: Initial coding in Excel

The colour-coded areas were collated and corresponding sections of the narratives were compiled into a worksheet for second readers to peruse. The initial worksheet contained three sections: one column contained the narrative and one column contained the précis of what the researcher and the second readers had interpreted as emerging codes; the third section reported interpretation of values and how the

participant was seen to exist using HTMETS (Figure 20). This section also provided space for notations or explanations or other concerns the researcher or second readers may have had. Cohen, Kahn and Steeves (2000, p. 66) reported that précis sheets record ‘substantive and theoretical hunches, ideas, insights and observations’.

To ensure they were addressed the guiding questions were included throughout paragraphs of the narratives to indicate where the researcher considered the research questions were answered. These narrative paragraphs usually addressed more than one of the five guiding questions. These précis sheets included not only initial interpretations but also more in-depth coding during the interactive process of dialoguing with second readers. In addition, any confusing information and areas not understood were recorded.

As explained earlier, the three modes of existence were identified as authentic, inauthentic and undifferentiated modes of engagement, which occur in the context of working with others. Narratives were searched for signs of areas of concerns, issues, values or instances that appeared meaningful to participants. However, determining what a participant valued was the first step in operationalising HTMETS. The second step was to interpret how participants were experiencing distress through verbal and nonverbal cues of anxiety or in their expression of concern. The third step was to search for instances where participants turned away or towards authentic behaviour in a response to their level of concern. Figure 41 is a small segment of the worksheet and précis.

Linking several narratives together	Relationships – CF support by HE
<p>Ashley 34.57 Something that has bothered me is the lack of a. training and b. evaluation of clinical facilitators. In all my time, in the last four years of performing in this role, I have never been evaluated. (Q2) I have been told “you’re doing a great job, thanks very much”, but nothing formal, and I think that’s, that worries me. Not only about, I’d like to get some feedback, I’d like to know how, how to improve or where I am going well, and what I need to do to go even better. (Q4) But there is nothing, there’s no formal evaluation, although I have asked for it.</p>	<p><i>Q2 No formal evaluation of CF</i></p> <p><i>Q4 Lack of formal assessment limits ability to improve on preparing students for professional practice</i></p>
<p><i>Values: support, responsibility, being valued</i></p> <p><i>Authentic engagement: This CF recognises the challenges inherit within the process and skills of CF’s and acknowledges how she feels. Her actions are actively engaged in making a difference to students and in building the relationship with HS staff. In this sense, she is providing support to HS staff and students and being responsible. She values the support that she is providing for students and considers the role of immense value – It “is more than just a job.” In this authentic engagement, she still has stress associated with trying to deliver good support with a feeling that she is somewhat alone in trying to deliver it “In no man’s land.”</i></p>	

Figure 41: Initial coding on worksheet

Figure 41 illustrates the parts of the narrative that are linked to relationships of support: the CF in this instance felt she was not supported by the HEP’s clinical team. Q2 was initially coded as a barrier to supporting students more effectively and Q4 was interpreted as influencing the participant in identifying, assessing and managing students effectively; there was a sense of not being listened to. In this example, the participant valued the opportunity to improve in her role as a facilitator and strived to have her evaluations recognised. The next section further explains how the themes were developed.

3.2.2.2 Developing Themes

Smith and Osborn (2007) and Pope and Mays (1995) described the iterative process as one where researchers look for the ‘clustering’ of themes (p. 72). However, Turner (2010) and Smith and Osborn (2007) reported that in IPA inquiries there appears to be no set way to develop themes. Smith and Osborn (2007) added that when all narrative content from individual cases are included and treated as data, researchers can commence theming by developing first and second constructs. As connections are

made between individual cases, the themes begin to emerge. The development of themes assisted with the emergence of a framework and the writing up of exemplars.

Once second readers had provided their input, the various codes were evaluated, printed, cut and moved around on a flat surface until the emerging themes were identified (Smith & Osborn, 2007). The emerging themes were selected where commonality or similarity was seen between first order constructs. Figure 42 provides an example of emerging first and second order constructs.

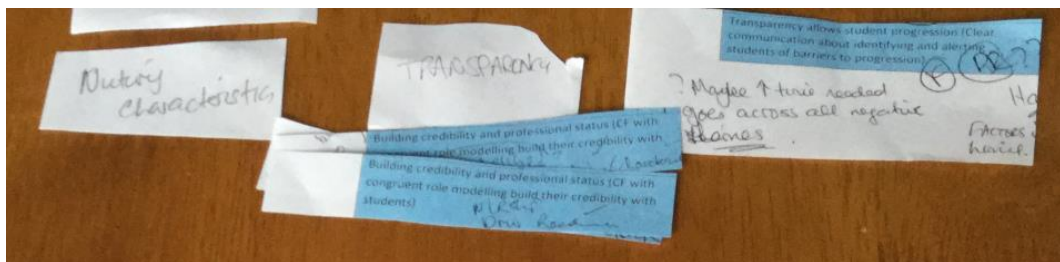


Figure 42: First and second order constructs

Emerging themes initially provided some insight into how to best place or theme up the phenomenon. Comprehending and interpreting the themes was initially attached to individual stakeholders for showing responsibility and accountability throughout the facilitation of a student's final placement. As themes overlapped between stakeholders, the themes were discussed with my supervisors and were then later distilled to show the overarching themes and to show that all aspects of the paradigm related to students, the CF, the HEPs and the HSPs.

An initial framework was developed to explain the participant journey of managing students on a final placement in becoming ready for the role of the RN. As the journey was complex, several refinements of the framework and its major themes occurred when exemplars were reviewed. Second readers and participants added their interpretations about the meanings until saturation of the data occurred. (See Section 3.2.3.1).

A small sample of information rich informers of in-depth interviews should address the research objectives (Gentles, Charles, Phloeg, & McGibbon., 2015) and provide saturation of the data (Polit & Beck, 2008). This is likely to occur when the breadth of the inquiry does not identify any new information. However, while phenomenological studies expect saturation to occur in their approaches, the interpretative approach is

less likely to achieve this, particularly if it is using a small number of cases (Gentles et al., 2015; Smith et al., 2009). Whitehead (2004) explained that saturation of the data is not sought as absolute truth is the temporality of engaging with others and entities. However, Smith et al. (2009) pointed out that while these cases represent a specific sample, the characteristics may be typical of a wider group of individuals with similar characteristics.

In this inquiry, the recognition of characteristics and behaviour began to emerge by the third interview, and by the interview with the ninth participant, the overall interpretation was seen to map out how this phenomenon occurred. No further participants were needed. Participants and other expert CFs confirmed the interpretations by viewing the overarching themes. Although generalisability cannot be assumed (Smith & Osborn, 2007; Speziale & Carpenter, 2007), it is likely that the findings are generalisable as the homogeneity of the sample means they are likely to reflect the wider population of CFs.

Questions tabled for a second interview were eliminated by the fifth interview. As more participants were interviewed, these questions were answered and participants were more likely to lead the conversation. I had relaxed more with the interviewing process and could see that participants had similar experiences and concerns. In these interviews, the guiding questions were only asked if the participant had not addressed them. Participants' experiences confirmed that the emerging framework explained the phenomenon.

3.2.3 Aspect 3: Second Readers and Participants

The first two aspects have been explained. Aspect 3 now describes how the second readers and participants confirmed or disputed experiences and interpretations related to the themes. This input was required from second readers after the first and second constructs had been developed. Following this step, an initial theming and a developing framework had commenced, and participants were invited to a second interview to provide clarification and further input (HPR #2, 5, 8, 9, 16, 18).

This stage appeared to correlate with Ajjawi and Higgs's (2007) stage 6 of integration and critique where the data are critiqued by the researchers and through external

sources to refine the themes. Figure 43 indicates the people who were involved in the collection of data: second readers and participants.

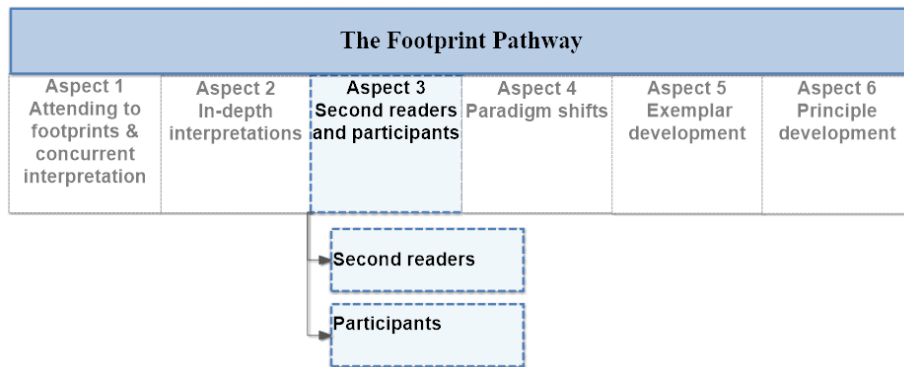


Figure 43: Second readers and participants

3.2.3.1 Second Readers

Second readers are integral to the interpretative process. They provide a wider scrutiny of phenomena than do researchers, ‘give consensual validation’ and include their interpretations (Conroy, 2003). Smith et al. (2009) confirmed that wider scrutiny verifies findings. Second readers provide their insight into not only the initial coding of data, but also the refining of the paradigm and the framework. This contrasts with the scientific approach where validation occurs when specific and set measurements can be ascertained and confirmed.

Second readers in this study were given an overview of the three hermeneutical tools, a blank worksheet with participants’ narratives and my worksheet and notes. At the top of each participant’s worksheet, instructions were provided to assist readers when reading and interpreting narratives. The instructions were supplied each time selections of narratives were sent to second readers, to ensure consistency. Figure 44 presents these instructions.

Process for Analysis: provides information of how various emerging themes may relate to the research questions

Explanation for second readers: this process will ensure that the research questions are answered and will clearly explain the process that is undertaken.

- Each emerging them is noted by the researcher and connected to a research question. It is possible that themes may emerge more than once throughout each narrative section.
- The researcher analyses how the CF is engaged in the facilitation process using the model as set out by Heidegger's three modes of existing or taking a stand.
- In the researchers Notes the researcher will sum up what the narrative has shown.
- The researcher's initial themes and notes are sent to the second readers along with a blind reading.
- **Second readers** can form their own themes without any bias from the researcher.
- **The second reader** is asked to consider what values appear to be important to the CF.
- **The second reader** is asked to consider if the CF's actions are disengaged from these values (see Heidegger's three modes of existing or taking a stand". This section is important as it shows how the disowning or failing to take a stand for these values may produce stress within the participant and impact how students become prepared.
- **The second reader** is then able to check what the researcher has found and further dispute or confirm the findings.
- From this compilation of emerging themes, the overall themes will be extracted by the researcher.

Figure 44: Second readers' instructions for analysis

Second readers examined the narratives to determine what participants valued. They determined instances of distress and how participants turned away or towards authentic behaviour (HTMETS). Second readers used their blank worksheet to make independent interpretations using the tools to guide them. They then read the researchers fully worked-up case or précis section so that they could discuss further the differences and similarities between interpretations.

On the receipt of the second readers' worksheets, further notations were made about their interpretations in column two where convergence and divergence of coding was apparent. Second readers recorded in the third section of the worksheet instances about the participant's values and when they were anxious. They included general meanings about the participant's experiences. Further dialogue with second readers about diverging codes was re-examined and explored with second readers (HPR #2, 3, 7, 17). Figure 45 illustrates the consideration of converging and diverging meanings made by the researcher and the second readers.

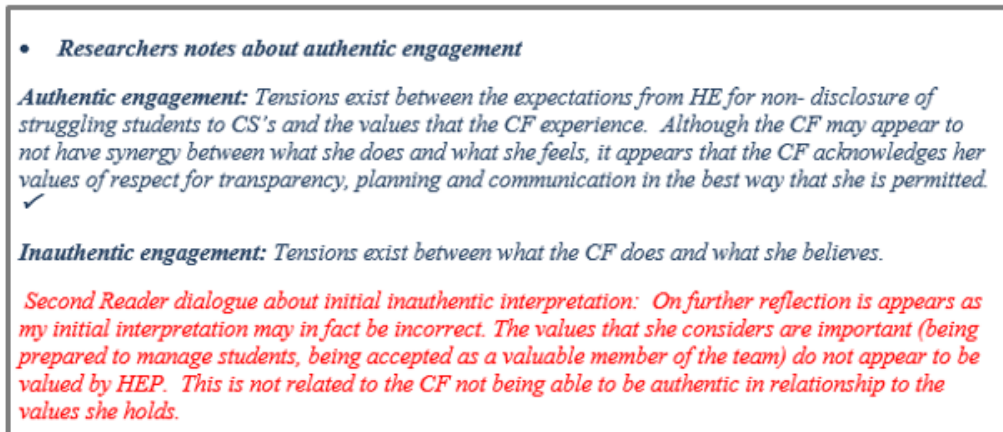


Figure 45: The managing of converging and diverging interpretations

Second readers were also involved in forming up the framework that illustrated the answer to the research questions. Second reader inclusion is further described in Aspect 4. In addition to second readers' input, participants were invited to peruse the themes and the emerging framework to clarify and provide any additional information about their experiences.

3.2.3.2 Participants

For the second interview, participants were given an opportunity to provide further information pertaining to their experiences. It was also an opportunity for me to ask further questions related to the first interview. However, during the inquiry, further questions planned for the first few participants in the second interview did not always need following up, as other participants in the first interviews began to reveal these answers. These findings were incorporated into the emerging themes and clarified during the second interview with all participants.

For the second interview, participants were sent a preliminary outline of the emerging themes and framework. Consequently, participants were given a lot of detail about the themes and codes to peruse before the second interview. The detail provided a summary of the enabling and hindering factors, themes outlining the initial findings and the emerging conceptual diagrams related to the phenomenon.

The second interview with participants commenced with re-establishing rapport and obtaining verbal permission to record the interview. Participants were invited to provide any additional information they felt was necessary. Participants agreed with

most of the findings and where they disagreed, they provided an explanation. Converging and diverging explanations are provided throughout the findings.

Further refinement of the themes occurred during the framework development and the selection of exemplars following second interviews. This action of collaborating with individuals confirmed which points were significant (HPR #18) and added further insight into why participants diverged from the common experiences found. Although not exhaustive, the major supporting tools utilised here were the HDC #11, 15 where further understanding was sought. The HPR #8, 9, 14, 18 were incorporated and illustrated the spiralling process of interpretation. All participants were provided an opportunity to review the final themes and framework via phone or email and to contribute towards clarifying this journey (HPR #2, 9, 16). They were sent an email outlining the beginning framework and the collation of themes (see Figure 46).

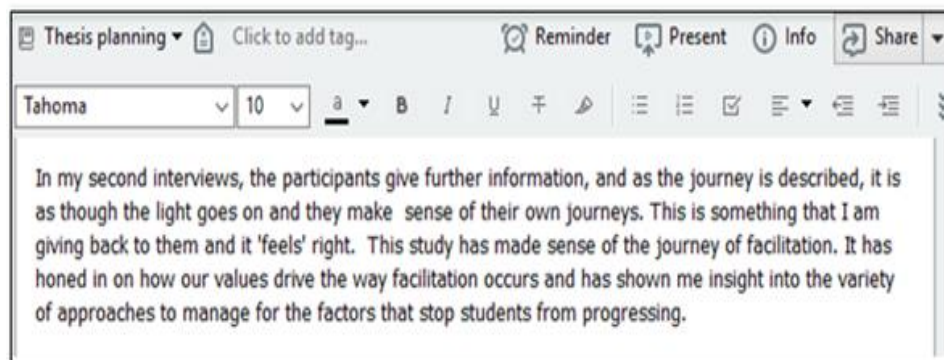


Figure 46: Reflection on research journey

All who participated in the inquiry were sent a thankyou letter. The letter outlined an opportunity to have access to the published findings. Participants were made aware that they would be informed of the results of the study.

3.2.4 Aspect 4: Paradigm Shift Identification

The first three aspects have been explained. Aspect 4 describes how the identification of paradigm shifts occurs. Smith et al. (2009) recognised that emerging interpretations can be descriptive as the researcher tries to explain all phenomena relevant to the topic of study. However, the emerging themes must be more than just descriptive when interpretative inquiries are conducted. The term 'paradigm' was reported by Thomas Kuhn (1970) as a constant shift or a change in how one views the phenomena. An

instance where this can occur is where a researcher replaces a previous framework or model with a newer model to enhance understanding and problem solving (Kuhn, 1970).

Conroy (2003) supported the idea that a paradigm shift is a change in seeing the world, and this occurs when researchers or an individual make new interpretations from the experiences they have encountered. Paradigm shifts can occur throughout the course of an individual’s experiences with individuals and inanimate entities, and as they engage and exist within organisational, social, personal and other contexts. Individuals make new meanings from these experiences and in turn may move towards or away from engaging with individuals and inanimate entities (Conroy, 2003). Conroy (2003) supported Hoy’s (1996) term for this shift as a ‘hermeneutic turn’ and purposely distinguished this from the themes and the exemplars.

In this inquiry, I experienced a shift in interpretations and turned towards seeing the phenomenon in greater complexity. Understanding also moved from knowing what happened to knowing how individuals moved towards or away from their prioritised values (see Figure 47).

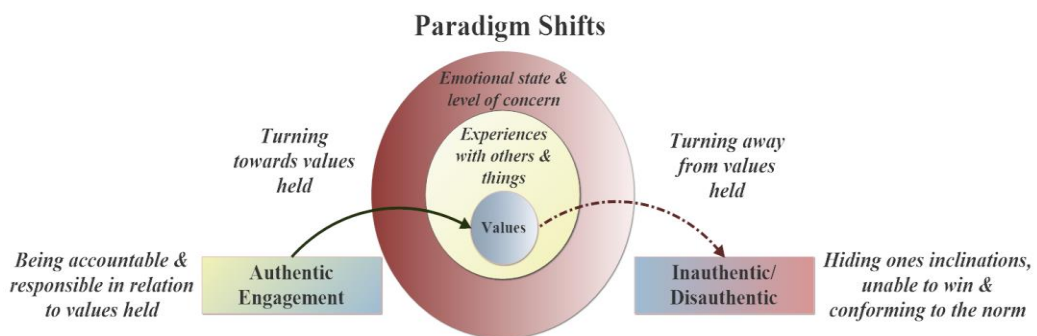


Figure 47: An interpretation of the paradigm shifts

In Figure 47, the unbroken arrow illustrates how individuals consciously turned towards their values as they had a strong commitment for an authentic existence, whereas the segmented arrow illustrates how individuals consciously or subconsciously turned away from values and disowned responsibility or failure. The shifts participants made from being confronted or supported by the psychosocial and contextual influence of the workplace are explained in the findings. The paradigm shifts are titled, ‘Exposing the hermeneutic turn of the researcher’ and ‘Exposing the hermeneutic turn of participants’ (see Figure 48).

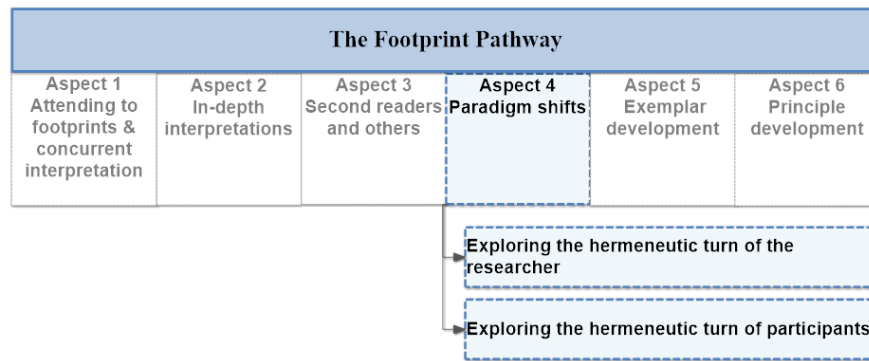


Figure 48: Paradigm shifts of the researcher and participants

In this study, the researcher was central to the inquiry and interpretations about the phenomenon appeared before the inquiry was commenced. How my stance changed as a result of this research is described in the next section.

3.2.4.1 Exposing the Hermeneutic Turn of the Researcher

In reflection on my assumptions and experiences, I valued giving students the opportunities to learn. Although I had some idea of the issues that other CFs experienced, I perceived the CF as constrained in managing these issues but did not clearly see how these constraints always occurred. However, during this study a paradigm shift or shift in my thinking occurred. This shift in thinking was that the participants’ facilitation role was one of travelling with others; it was a ‘journey’ where the responsibility for preparing or not preparing students was a shared responsibility. I moved from recognising some of the obstacles associated with managing students to seeing the broader context of how the obstacles were significant in affecting readiness and acquiring independent practice.

In this inquiry, the paradigm emerged as seeing the participants take a journey down a road that was already paved—not only by the providers of HEPs and HSPs, but by HSS, the student and the participants. The influencing factors were broad and complex. Figure 49 illustrates the phenomenon as a shared journey.

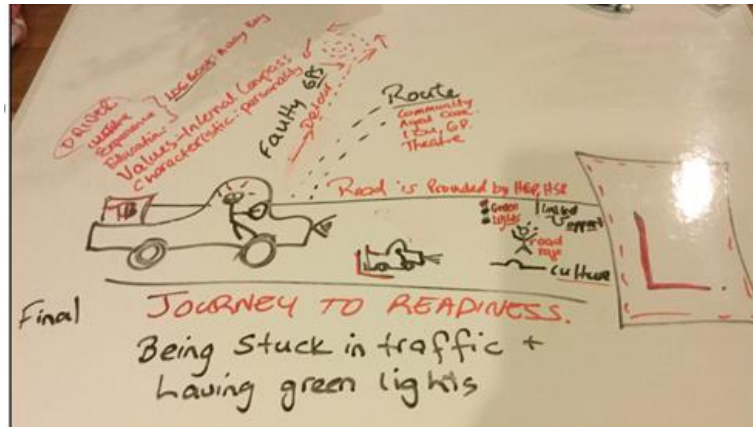


Figure 49: An interpretation of a shared journey

To explain this paradigm a framework was developed. The themes were organised initially into a framework that was refined several times with the input of second readers, participants and others. The emerging framework was developed from the lived experience of participants, but the paradigm incorporates the complexity of working alongside other individuals or within the context of organisations. The emerging framework captured how these systems of support were perceived during this inquiry.

Although a few iterations were developed during the process of refinement, the final framework was created during the selection of exemplars. The phenomenon is derived from the participants' descriptions and the meanings they took from their experiences. Figure 50 illustrates two iterations of the developing framework.

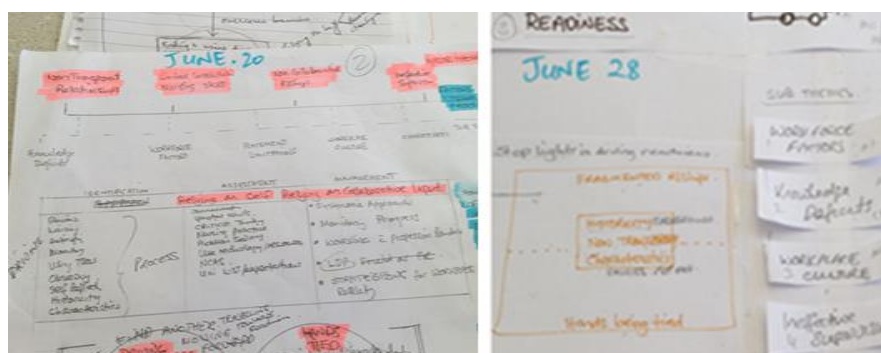


Figure 50: Forming themes and commencement of framework

3.2.4.2 Exposing the Hermeneutic Turn of Participants

These developed frameworks were also interpreted for instances where participants turned towards or away from their values. In this study, the turning away or towards

their values was significant to the support they provided for a student’s final placement. Authentic and inauthentic behaviour becomes evident throughout the exemplars and interpretations made throughout the findings chapters: Chapter 4, 5, 6 and 7.

3.2.5 Aspect 5: Exemplar Development

The first four aspects have been explained. The fifth aspect is that of exemplar development (see Figure 51).

The Footprint Pathway					
Aspect 1 Attending to footprints & concurrent interpretation	Aspect 2 In-depth interpretations	Aspect 3 Second readers and others	Aspect 4 Paradigm shifts	Aspect 5 Exemplar development	Aspect 6 Principle development

Figure 51: Exemplar development

In Patricia Benner’s (1994) third step, she obtained the exemplars that would reflect the paradigm. It is through exemplars that readers can confirm the researcher’s conclusions (Polit & Beck, 2008). Conroy (2003, p. 32) explained that an exemplar for a theme is ‘a case which demonstrates consistency in concerns, meanings, knowledge, values and/or skills common to a participant’s experience in the world.’

An exemplar that best represents the phenomenon can be drawn from the narratives. Conroy (2003) considered that drawing exemplars can occur from an individual narration alongside an aggregate archetype where similarity is found across many narratives. As suggested by Conroy, and as there may be differences in participants’ backgrounds that influenced their experiences, both singular and aggregate exemplars are used to assist the reader to understand the phenomenon.

Pringle et al. (2011) warned researchers that the interpretations must be supported with evidence consisting of participants’ direct quotes. Ajjawi and Higgs (2007) identified that exemplars show a researcher’s dialogues about the text and its meaning. In addition, Smith et al. (2009) suggested that in-depth engagement with the data should include not only a description but an interpretation of the meanings. As exemplars are complex and can include many factors, each exemplar was carefully considered for its placement in themes (see Figure 52 for a reflection on positioning the exemplars).

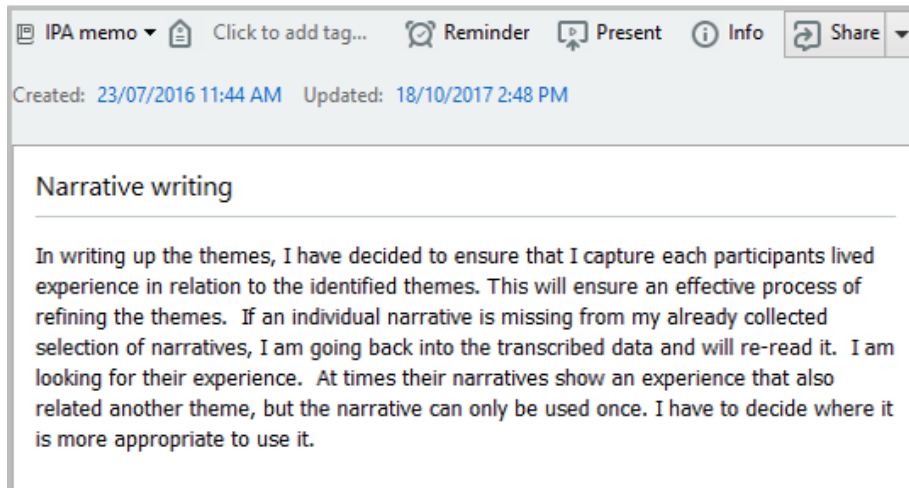


Figure 52: Positioning exemplars

Narratives were re-read to extract excerpts that would explain how participants had supported students. These experiences are reported in a literary style as recommended by Speziale and Carpenter (2007). The exemplars were chosen to reflect the framework as this aptly described the participant journey. As discussed earlier, the HPR, HDC and HTMETS were influential in maintaining consistency in the application of the hermeneutic methods, as indicated with exemplars.

3.2.6 Aspect 6: Principle Development

The first five aspects have been explained. The sixth aspect is principle development (see Figure 53).

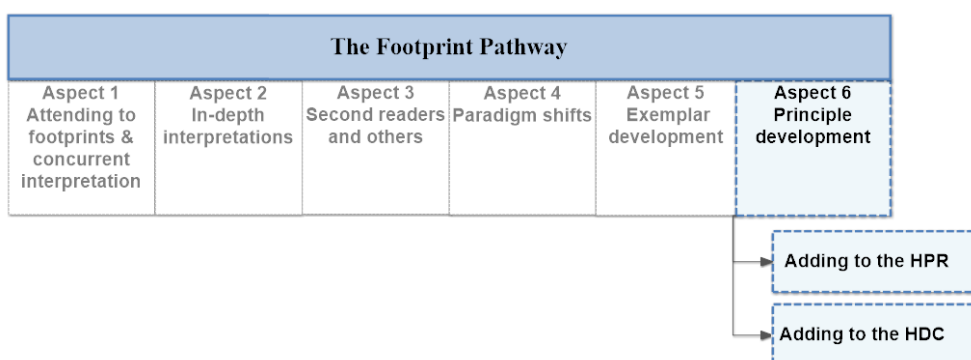


Figure 53: Aspect 6—Principle development

Conroy (2003, p. 19) identified that principles are ‘derived inductively from the footprints and interpretations’ and that these principles are significant to the method of IPA. These HPR maintained focus on what was important, for example, by asking,

‘Is this really what the participant was saying?’. Both the HPR and HDC required minor changes for this inquiry. This section describes how changes were made to the principles Conroy had compiled.

3.2.6.1 Adding to the Hermeneutic Principles of Research

Conroy (2003) recommended researchers add principles that can generically apply to the participants in the research and suggested a process by which to add to these principles. She recommended that written transcripts and audio recordings are provided back to participants and to others. Guiding principles were included in the HPR to cover this expectation (HPR #5, 6, 8 & 10). However, other researchers using IPA approaches have reported that they were concerned with providing audio or written transcripts back to participants.

Mero-Jaffe (2011) and Hagens, Dobrow and Chafe (2009) identified dilemmas associated with researchers who send participants the transcript of their interview. Although Conroy (2003) found this establishes trustworthiness, Mero-Jaffe (2011) considered transcripts generally show a lack of coherence that when transcribed verbatim can be distressing for participants. The provision of verbatim transcripts to participants would empower them and give them an opportunity to refine, clarify, approve or disapprove of the text. Consequently, inquiry findings would need to change and the integrity of the inquiry would be placed at risk.

Hagens et al. (2009) expressed concern that rich textual data from participants could be modified. They considered that the ethical stance to protect participants is to omit data removed from narratives. Scotland (2012) also was concerned that on the discovery of secrets or abusive relationships, the reviewer might need to consider intervening. Scotland (2012) suggested to tone down context information; however this implies that the findings may not reflect the phenomenon. Further, Hagens et al. (2009) identified that the review of transcripts for verification against audio recordings does little to establish accuracy or improve rigour. Mero-Jaffe (2011, p. 244) cautioned researchers:

transference of transcripts to participants raised methodological problems, ethical problems, and problems of research credibility ... It would appear

that considerable thought must be given during the stages of carrying out research as to whether transcripts should be given to the participants.

Conroy (2003) acknowledged that researchers might wish to add to the HPR. In this study, given the supervisors' concerns with providing transcripts to participants, the following process was followed: participants were not provided with verbatim transcripts or digital recordings; and because the voices of participants might have been recognised by second readers, second readers were not provided with the voice recordings to ensure that no breach of confidentiality could occur. In addition, HPR #10 was modified to offer participants an overview of my understandings and interpretations rather than offering a narrative account.

3.2.6.2 Adding to the Hermeneutical Development of Commentary

In the operationalising of the HDC, colour coding was added to the commentary to identify when the researcher could best use each of the commentary questions. In this inquiry, three additional changes were made. These were related to the HDC #3 and the notes made at the bottom of the commentary. HDC #3 included an additional question to ask: 'What significant factors turn participants away or towards another mode of existence?'. This was to ensure that the narratives would be examined for influential or contextual factors (Figure 22).

The second change was made in the notes section where 'bolding of text' had replaced the words with 'underlining in text' to show emphasis in the transcript of each participant's dialogue. During this inquiry, a further question was added to the HDC: 'Does the précis show where the thought and meaning across segments answer the questions related to the research question?'. By making these changes to the HDC, the inquiry was seen to answer the research question in the manner of this interpretative inquiry and was likely to increase the rigour applied to the exploration of the phenomenon.

3.2.7 Rigour

Rigour in qualitative research involves showing readers exactly what was done and how decisions were made throughout the inquiry (Cohen et al., 2000). Tobin, Begley and Tobin (2004) considered that 'Rigour is the means by which we show integrity

and competence: it is about ethics and politics, regardless of the paradigm' (p. 390). Smith et al. (2009) added that rigour must be evident during the process of the inquiry rather than at the end of the inquiry. Speziale and Carpenter (2007) indicated rigour is seen when the researcher is attentive to the details of the inquiry, and where they have sought confirmation from others.

Murphy and Yelder (2010, p. 3) stated that qualitative inquiries do not use statistical tests but act to 'take note of personal history, values, attitudes and either acknowledge or bracket (remove) them before the data is clustered and summarised'. However, other experts see similarities between terms used for both paradigms (Billups, 2014; Denzin & Lincoln, 2018; Murphy & Yelder, 2010; Pandey & Patnaik, 2014). All approaches seek the correctness or truth about the research questions asked.

Denzin and Lincoln (2018) considered that having certainty about the rigour of an inquiry would occur if verification and validation were incorporated into the design and sampling specifications, the analysis, the collaborative input to check the results, knowing when saturation had been met and adhering to the stated methodological approach. The following sections describe validity and reliability in terms of trustworthiness. These terms show how this inquiry met these tests of rigour.

3.2.7.1 Trustworthiness Model

In qualitative or naturalistic terms, rigour is not seen through measurable variables but as concepts such as goodness and trustworthiness (Murphy & Yelder, 2010). Denzin and Lincoln (2018) indicated that both 'internal and external validity are replaced by such terms as trustworthiness and authenticity' (p. 98). Pandey and Patnaik (2014) described the term used in qualitative inquiries as 'verification'. Verification occurs when no further new information emerges and when others provide feedback (Denzin & Lincoln, 2018, p. 796).

In this inquiry, Murphy and Yelder's (2010) proposed model was used to describe how rigour had occurred throughout. Figure 54 illustrates that each attribute does not occur in a linear progression but occurs concurrently throughout the inquiry.

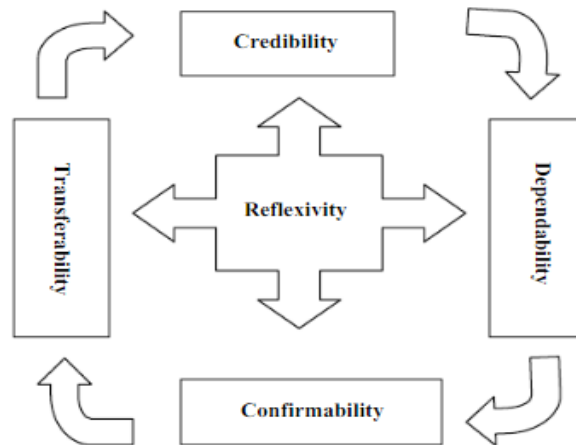


Figure 54: Proposed model for the assessment of trustworthiness in qualitative research (Murphy & Yelder, 2010, p. 5, adapted from Guba & Lincoln, 1992) (Permission obtained)

These attributes are termed credibility, dependability, transferability, confirmability and reflexivity (Denzin & Lincoln, 2018), and have replaced the quantitative terms of validity, reliability, generalisability, objectivity and accuracy. These five terms are now discussed with supporting or discounting perspectives from Conroy (2003) and other sources.

3.2.7.1.1 Credibility

Credibility is an attribute that explains the truth value of the inquiry (Conroy, 2003). It is likened to internal validity in quantitative inquiries and increases the confidence in the truthfulness about the findings (Pandey & Patnaik, 2014). Denzin and Lincoln (2018) suggested that actions used with guiding questions and the collection of the data show credibility if these actions ascertain meaning. Thomas (2010) warned researchers that credibility in a naturalistic approach is at risk when the design, observations, collection and interpretation of data are biased by the researcher.

Murphy and Yelder (2010) recommended four strategies to assess credibility, reduce bias or mitigate for possible weakness that are inherited from the approach. The first strategy uses member checking, participant validation or a third party to establish feedback. The second is the use of extended engagement with participants and immersion in their data, which is likely to build trustworthiness. Third, peer debriefing can be used (Denzin & Lincoln, 2018; Murphy & Yelder, 2010). An inquiry's

credibility is established if researchers have the intent to engage in conversations with knowledgeable individuals to answer critical questions (Murphy & Yelder, 2010). The fourth strategy is to use triangulation from a variety of documents, methods or other researchers to ‘cross check’ and confirm the completeness of the findings (Tobin et al., 2004).

The use of research throughout the inquiry, reflexivity and Conroy’s HPR tools (Conroy, 2003) were all carefully considered before the decision was made to not send transcripts or digital recordings to specific individuals. I was required to be flexible when implementing aspects of this design (see the reflexive note in Figure 55).

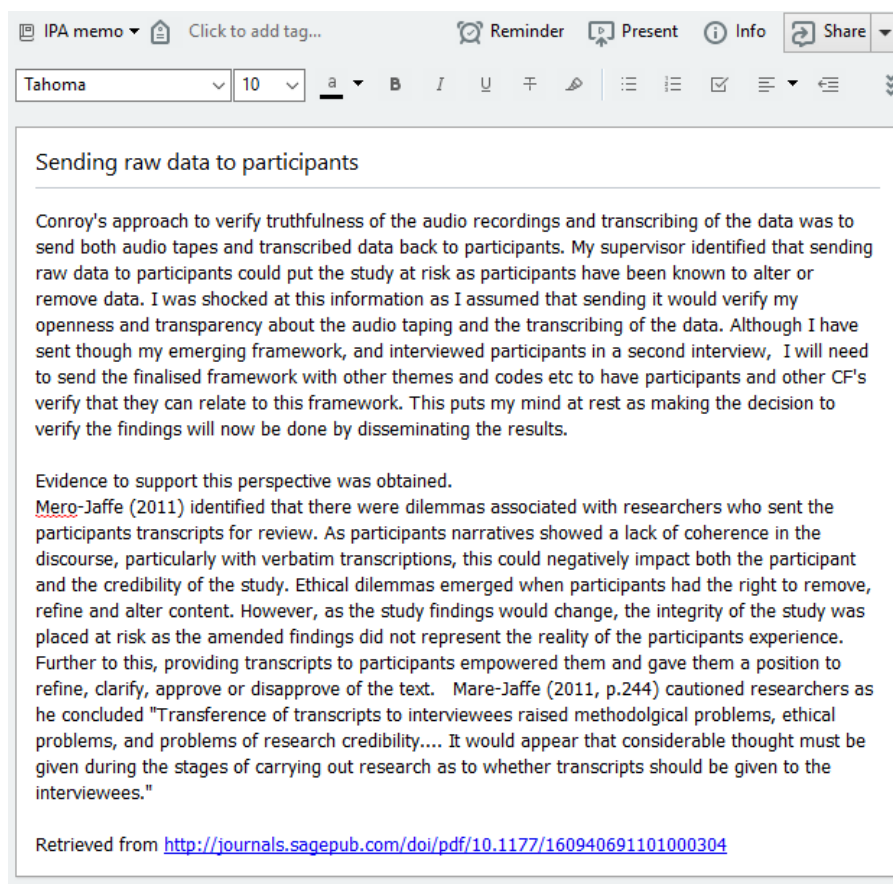


Figure 55: Decisional trail regarding participant transcripts

Collaboration occurred with others in various aspects of the footprint pathway to refine the emerging codes, themes and framework. The participants, supervisors and other CFs reviewed the emerging framework to clarify my interpretations. HPR #5, 9 were not followed and had to be amended to prevent stress to participants. These adjustments are recorded in ‘Aspect 6: Principle development’.

Mantzoukas (2005) identified that bias needs to be eliminated or minimalised in all inquiries. However, in the interpretivist approach the bias or assumptions of the researcher are identified in the inquiry through self-interview and self-report. In this study the reviews illuminated what these assumptions and biases were in the context of the guiding questions. In distilling out the meaning for participants, use of Conroy's tools for engaging and interpreting the data, prolonged engagement with participant data and input from participants and significant others gave this study credibility.

3.2.7.1.2 Dependability or Consistency (Reliability/Replicability)

Dependability is the qualitative term for reliability (Denzin & Lincoln, 2018). Dependability is evident in the details about the methodological approach, the data analysis and the discussion (Murphy & Yelder, 2010). If the inquiry were to be repeated, the results are likely to be similar (Mabuza, Govender, Ogunbanjo, & Mash, 2014). A stable instrument can consistently provide similar results over a period. This repeatability can be enhanced when homogeneity occurs, or when subjects have the same characteristics (Mabuza et al., 2014; Verhonick & Seaman, 1982).

To provide the opportunity for replicability, reflexive notes, details about the methodological approach and data analysis are documented and described. Billups (2014) iterated that external audits generate 'trustfulness' about the inquiry. As Evernote reflection and reflexivity is demonstrated throughout this inquiry and the self-interview and self-report are included, the reader can have greater confidence in the truthfulness of this enquiry. Discussions about converging and diverging findings also show how this study is credible and likely to apply in another setting with a similar population.

3.2.7.1.3 Transferability or Applicability

Conroy (2003) identified fittingness as an attribute that demonstrates how findings are likely to be applicable or transferable to another setting. She reported that this 'is confirmed by interest shown by all participants and the greater community' (p. 34). Transferability in qualitative inquiries is also demonstrated when findings can be transferred between cases rather than that of the general population (Murphy & Yelder, 2010) and if applicable in a similar setting (Billups, 2014; Golafshani, 2003)

The goodness of fit is another term to show how participants' views are mirrored in the researcher's representation (Murphy & Yelder, 2010).

Tobin et al. (2004) recommended goodness of fit be shown in methodology, methods and the recognition of 'multicultural subjects' (p. 391). It includes the researcher's intention, their interpretations throughout each aspect of the inquiry and the inclusion of recommendations for future practice. In this study, these elements are seen throughout the provision of thick descriptions that take into account the maturation and time taken for the inquiry, the settings and participant information, and throughout the findings (Lincoln & Guba, 1985; Mabuza et al., 2014). In this study, the before-and-after-interview reflections were audibly collected or documented via Evernote.

In hermeneutic inquiries, transferability might alter when participants come from varying professional and social backgrounds, as the heuristic focus is on the diversity of experiences (Mabuza et al., 2014). The researcher is expected to highlight convergence and divergence in the findings 'rather than focusing solely on commonalities' (Pringle et al., 2011, p. 2). Leung (2015) recognised that results can vary between samples with unique experiences, but advocated for consistency as a critical element of transferability. In this study divergence and convergence of the findings is identified. Although a Western Australian study, the results are likely to be transferable to CFs residing in other states of Australia.

3.2.7.1.4 Confirmability or Neutrality

Confirmability is related to objectivity (Denzin & Lincoln, 2018) or to neutrality Golafshani (2003). Neutrality requires that value judgements are not made by the researcher as they focus on the collection of data, the research process, the relevance of the meanings and where they will use reflexivity (Denzin & Lincoln, 2018). Mabuza et al. (2014) identified that when data are collected and reported objectively, and where the researcher is aware of their own responses, trustworthiness is likely to be obtained.

Confirmability or objectivity can be seen when the researcher is open about their prior relationships with participants and about other background information related to their professional employment and capacity (Mabuza et al., 2014). These sources confirm that a researcher is aware of their accountability and assumptions while interpreting another's experience (Murphy & Yelder, 2010). However, participants who are

vulnerable to barriers between the researchers and themselves can be related to culture, language or position will not reveal the truth about their experiences (Mabuza et al., 2014). In this inquiry, cultural, language and positional barriers with the participants did not occur.

Barbour (2001) outlined that confirmability can be obtained by checking coding strategies and interpretations with significant others. These original interpretations may change as data are re-read and re-interpreted. An audit trail shows evidence of collaboration and confirmation with others (Denzel & Lincoln, 2018; Murphy & Yelder, 2009). As supported by Murphy and Yelder (2009) and Denzel and Lincoln (2018), this thesis describes and demonstrates attributes of trustworthiness by revealing parts of a reflexive diary.

3.2.7.1.5 Trustworthiness

Trustworthiness can be seen in an audit trail and through the observation of reflexivity (Murphy & Yelder, 2010), processes and documentation (Murphy & Yelder, 2009; Ryan et al., 2007). Denzin and Lincoln (2018) clarified these as internal audits where the researchers deliberately monitor their work and demonstrate trustworthiness.

Data are collected from the journaling of the researcher, which includes reflections, insights and dialogue on how decisions are made. Reflexivity is a process used to demonstrate and reveal the researcher's 'process of intellectual construction that shaped the "structure of encounter"' (Larkin et al., 2006, p. 107). Thomas (2010) pointed out that subjectivity is criticised in naturalistic approaches as there is no objectivity in a scientific sense. Larkin et al. (2006, p. 109) warned against describing the naturalistic approach 'in terms of mere "subjectivity"'. It is apparent what is objective and what is subjective cannot be teased apart in any simple fashion'. Tobin et al. (2004) posited that by proving the researcher's approach was unbiased, intellectual and scientific acceptance is assured.

Brocki and Wearden (2006) suggested that to ensure credibility throughout an interpretative inquiry, researchers should outline their beliefs and preconceptions, demonstrate reflexivity and show transparency. Being central to the inquiry requires the researcher to reflect and critically think about the meanings about the phenomenon (Mabuza et al., 2014). In this study, I utilised past documentation about my

experiences, and conducted a self-interview using the key questions that would guide the interviews of participants. Once the participants' interviews were themed, I went back into my own interview and themed the content.

3.3 Ethics Approval

Before conducting the inquiry, a low-risk review from (HREC) was obtained (approval number 014109F; Appendix D). Participation was voluntary and offered to a selection of CFs within WA. A plain language statement (Appendix B) was printed on university letterhead and sent to them. It stated the project purpose, title and name of the researcher, and included the supervisors' names. It also outlined the right of participants to withdraw at any time, the risks, privacy, confidentiality and assurance of anonymity. A consent form was given to participants at the time of the interview (Appendix G). In the second interview, these ethical processes were also applied: obtaining permission, having the right to withdraw at any time and having the conversation recorded. No written consent was obtained for the second interview as verbal consent was accepted.

The plain language statement and consent form outlined each aspect of the inquiry and set out how the protection of participant identity and information would be kept confidential. It also described the risks to participants and the benefit of participating in the inquiry. Contact details were provided for the HREC so that participants could contact them if they had any concerns about the research. Participants were shown where they could sign and date the consent form, which also included the signature of the researcher.

Protecting participants' right to privacy and confidentiality was always incorporated into the inquiry. Participants' narratives were given an ID number and a pseudonym to protect their identity. As home visits were requested for the interview, a master list was kept of the participant's real name and pseudonym with their address, phone number and email address. These data were important as I needed to be in contact and visit the participants for both initial and subsequent interviews.

Although considered a low-risk inquiry, efforts were made to minimise discomfort to clients by incorporating strategies to manage that risk. These strategies included

pausing to give the participant time to adjust, offering to turn the digital recording off, offering to cease the interview at any time, offering the contact details of a counsellor should the participant need support and rescheduling the interview if the participant agreed. There were several times when participants needed a moment to recoup, but these participants did not need me to turn the recorder off or stop the interview. All participants appeared settled when I left them. At the end of the inquiry, participants could notify the researcher if they wanted access to the final findings of the investigation. Once the inquiry was completed, they would be given access to the findings.

Raw materials such as digital recordings, field notes and worksheets were stored both electronically and in written form in my office. The raw audio files from the digital recorder were copied to my computer after every interview and wiped from the recorder at the completion of the study. These files are available only to me and were encrypted after transcription. Although the transcripts and my interpretation worksheets were provided for a short time to second readers, the second readers do not have access to participant details or to my computer files. The printed demographic data will be stored and retained securely for 5 years. At the end of five years, this data will be destroyed by Notre Dame.

3.4 Chapter Summary

This chapter has outlined the research paradigm and methods used in this study. The research paradigm identified the differences between quantitative and qualitative approaches; specifically, the use of phenomenology and the interpretivist approach. The methods used to discuss the six aspects of the enquiry process utilised Conroy's (2003) footprint pathway. Further, the importance and application of rigour were outlined. Chapter 4–7 describe and interpret the findings.

Chapter 4: Findings: Interpreting the Journey

4.1 Introduction

Chapter 3 outlined the research paradigm and methods used to conduct this inquiry. The chapter compared qualitative and quantitative paradigms, along with the phenomenological and interpretative approaches. The methods section in Chapter 3 discussed the six aspects of Conroy's (2003) 'footprint pathway' employed to capture and interpret the collected data. Chapter 4–7 describe the findings of this inquiry. This chapter commences with the demographics. The Steering Towards Readiness (STR) framework is introduced, followed by the details of the findings.

4.2 Demographic Data

This section describes the demographics of the participants. Demographics are attributes of participants (Burns & Grove, 1993). These attributes are outlined in Appendix F. Fifteen people were invited to participate in the study and nine accepted: eight females and one male. Of those who declined, three had initially agreed to participate but did not participate due to personal workloads, health reasons, or other reasons unknown to me.

All participants agreed to have their conversations audio recorded and were invited to take part in the second interview to follow up, confirm and dispute the findings and to provide further information about their lived experience. Six of the nine participants agreed to verify and dispute the findings in second round interviews. They also provided further input about the lived experience of facilitating final-semester nursing students.

The first interview was conducted face to face, while the second interview included four face-to-face and two interviews via the telephone. The average length of first interviews was 50 minutes and of second interviews, 67 minutes. After the interview all participants completed the demographic questions put to them. The employment details are provided in Table 2.

Table 2: Employment by educational providers and HSPs

Employed by HEPs and TAFEs	<i>n</i>	Percentage
Notre Dame University	6	67%
Curtin University	5	56%
Murdoch University	5	56%
Edith Cowan University	3	33%
TAFE	2	22%
University of Western Australia	1	11%
Currently practicing in a health setting	<i>n</i>	Percentage
Yes	6	67%
No	3	33%

The largest number of health settings in which a participant supported final-semester students was 10, while the lowest number was one. Collectively, the participants reported that they had worked for all five Western Australian HEPs; two participants had also worked within Technical and Further Education (TAFE) organisations. Six participants were employed by only one HEP while four participants were employed by HEP#1 and HEP#2.

Participants were asked, ‘Do you work as an RN in any other capacity outside of supervising nursing students?’. Six of the participants reported in the affirmative. Most participants were currently practicing in clinical areas. There were 10 different specialty areas in which participants practiced. These were, operating theatre, paediatric areas, medical and surgical settings, mental health areas, emergency department, aged care and day surgery. Some participants were also academics and worked in policy development, and quality and risk management departments. Two participants had only one role, which was facilitating students. Three participants had expertise in one area which was in addition to their clinical role. Two participants identified that they had clinical expertise in two additional nursing areas while two participants identified they had expertise in three professional areas of nursing.

Participants were asked ‘Have you received training in how to supervise undergraduate nursing students?’. Participants were not asked if they had acquired this

training before or after the commencement of the facilitation role. Seven (78%) of the participants had received some form of training for their facilitation role, with the remaining two received no training (22%) prior to supervising nursing students

Another demographic question asked was, ‘How many years have you been in a clinical educator role?’. Only one participant had worked for 1–5 years, six had worked for 5–9 years and two had an extensive period of 10 or more years in this role. The role of clinical educator includes that of clinical facilitation but could also encompass other educational roles.

Participants were also asked ‘How many final-semester students do you supervise in a year?’. Four participants had supervised less than 32 students per year. Five participants had supervised greater than 32 students per year. Although some participants referred to supervising more than just final-semester students, but this data was not collected as it was not within the scope of this study.

The next section describes the phenomenon of identifying, assessing and managing risk to nursing students on a final placement to being ready for the role of the RN. This was identified as a journey, situated in the contexts of drivers, providers and inanimate objects such as processes and systems.

4.3 Conceptualising the Contexts and the Journey

The conceptual framework for this study shows how CFs navigate around the factors that place students at risk of not being ready for beginning-level readiness. The STR framework appears as a forward journey where participants are bound by time to conduct the identification, assessment and management of risk. The way forward for students to obtain competency and support is already provided by the HEPs and the HSPs. The five major components of the CFs’ journey were identified as ‘The contexts’ of the providers and the CFs, the CFs’ ‘Responses to navigating traffic conditions’ and the three phases of the journey to I, A & M risk to readiness: Phase 1—Navigating current traffic conditions, Phase 2—Forging ahead and Phase 3—Reaching the destination. Figure 56 illustrates these major themes and secondary themes.

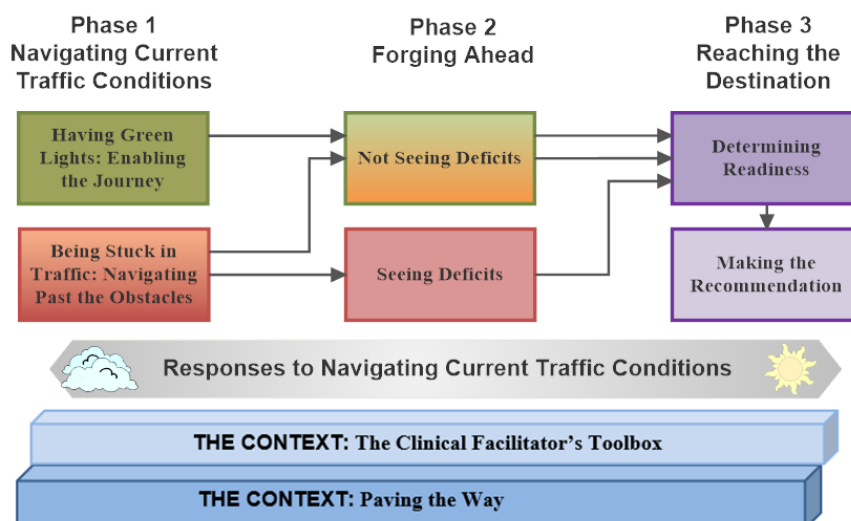


Figure 56: The Steering Towards Readiness framework

The illustrated framework in Figure 56 shows the major concept of ‘The context’ with two themes describing how organisations support ‘drivers’ such as the students, the CF and HSS. The parts of the STR framework are explained in Chapter 4–7 to enable readers to understand the complexity of the participants’ journey. An overview of the previous chapter is provided in the introduction of each of these four chapters. Table 3 identifies the themes and sub-themes of ‘The contexts’ of providers who paved the way for the journey, what tools participants used and how they felt about this journey.

Table 3: The contexts of providers and CFs

Themes	Sub-themes
The context: Paving the way	Variations of educational academic models Variations of facilitation models Variations of clinical supervisor models Variations of patient care models
The context: The clinical facilitator’s toolbox	The clinical facilitator’s guidebook—Familiarity & background Using high beam: Important values

4.4 The Contexts of Providers and Clinical Facilitators

The major concept of ‘The context’ describes how participants reported on the differences in processes and resources used by HEPs and HSPs to support student progression and supervisors in the identification, assessment and management of risk.

These processes or structures pave the way forward. Although these contextual factors have the potential to change, they are usually fixed and are less likely to be altered by providers. Figure 57 illustrates the contexts of providers and CFs. These themes are titled ‘The context: Paving the way’ and ‘The context: The clinical facilitator’s toolbox’.

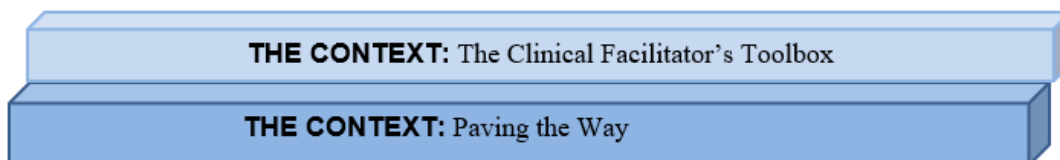


Figure 57: The contexts of providers and clinical facilitators

4.4.1 The Context: Paving the Way

This section describes in more detail the contextual findings of HSPs and HEPs use of various approaches or models to ‘pave the way’ for students to practice and for CFs to support students in the STR framework. These approaches are contextual to either the HEPs or the HSPs and are known as the models that support individuals or organisations and the workplace conditions. Elly reflected on how the workplace could affect student support:

Unfortunately, at the moment, I am seeing wards that you’ve got **all** grads but one staff member ... it can also be a negative if they are **not** a strong student (grad nurse) where they are sinking themselves, and they just look at the student as another, **another** burden really to and its hard work for them.

Four models were identified in the study that were relevant to the context of paving the way by HEPs and HSPs (see Figure 58).

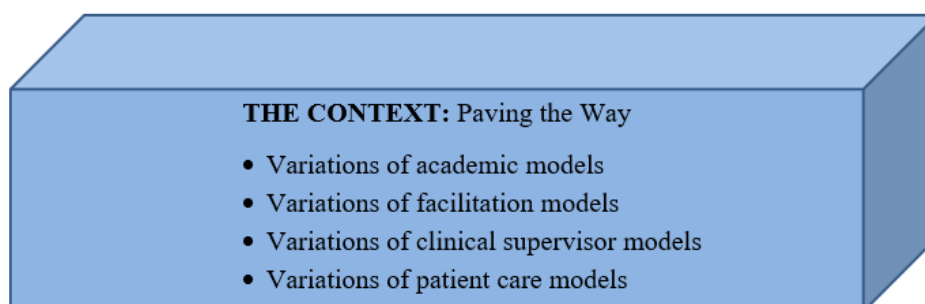


Figure 58: The context: Paving the way

These model variations describe how these approaches to support might be influenced by the contexts of providers that hinder or enable student progression and clinical support. The participants' narratives described where participants differed or agreed in their perspectives about the types of approaches used.

4.4.1.1 Variations of Academic Models

For students to undertake a clinical practice placement requires a team to place and manage the student from within the HEP. How the team is structured to support students varies among HEPs. The clinical teams for both the HEPs and HSPs are illustrated in Figure 59.

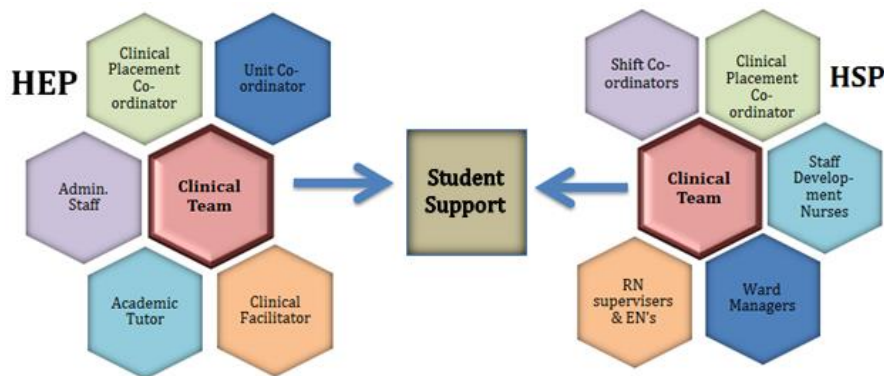


Figure 59: Researcher's interpretation of organisational support teams

Within academia, the clinical placement coordinator title may be a clinical director or a clinical practice coordinator. The clinical placement coordinator or clinical director liaises with the clinical placement coordinator of the relevant HSP to formalise student support agreements; determine the numbers of students who will be accepted into the health setting for their placement; formalise facilitator support arrangements; and sustain and build relationships with the HSP. The facilitator support arrangements may include organising facilitator support from either the HEP's or HSP's pool of staff. All CFs employed by the HEP liaise with individual members of the HEP and HSP clinical teams.

Several participants described the support they had received from various members of the HEP's clinical team. Ashley recounted that each university used different ways to support students and facilitators: '**Three different unis, they all ... coordinate student casement[sic] differently and therefore the interaction with facilitators is different**'.

Barbara reported that she would liaise with the ‘supervisor, or the tutor or the lecturer overseeing the unit’. Caroline reported that she would liaise with ‘the university unit coordinator’ when dealing with struggling students. Ashley felt strongly about differences in HEPs support with regard to the clinical placement coordinator and the unit coordinator. She reported:

When I work with [HEP#1] I work with one unit coordinator and I like that. The **unit coordinator usually knows who** I am talking about and may, therefore, be able to say, ‘Yes, we have had issues like this before’, or give some advice on how best on to handle a student ... Working with universities where there is **one placement coordinator for all students** who are out on prac, can be **very difficult to get hold** of them because they may have, I don’t know, 100–200 students out on prac and I appreciate that, you know, there are issues.

Not having ready access to academic support is likely to hinder CFs in managing risks.

Fiona would liaise with her ‘prac manager’ or the clinical placement coordinator and felt supported and valued by them as they listened to her concerns about a struggling student. The outcome of meeting was that her recommendations ‘were considered for future placements’. The benefits of both approaches have been identified. What is essential for managing risk is having trust and access to HEP support staff who valued the CF’s opinion.

The next sub-theme in ‘The context: Paving the way’ is the ‘Variations of facilitation models’. It will describe the support and specialty settings where participants had supported students.

4.4.1.2 Variations of Facilitation Models

Models used for clinical facilitation support depend on the contractual agreements between HEPs and HSPs. These models describe the operationalisation of clinical support for students, CFs and HSS. The HSPs are responsible for the safety of their patients and will take into consideration the level of the student’s education and the type of specialty that will provide students with the best opportunities given their level of training. When describing their experiences, the participants reported variations in the period of placements, number of students allocated to the CF, types of specialties,

hours for support and expectations for student and staff support. Summarised in Figure 60 are the differences in clinical practicums and support.

Clinical placements were for 1, 3 or 6 weeks for final-semester students. The number of students CFs supported was 7–25 students. The hours of support ranged from daily, weekly or on a shift-by-shift basis to after-hours support.

Ida’s narrative indicated she was seconded into her role from the health setting in which she had worked. She reported on placement time, expectations for the role, the number of students and the hours of support that she was expected to provide. Ida was the only participant seconded from a health setting and she provided additional insight into how this type of provider’s arrangements concerning the employment of CFs enabled her to support students.

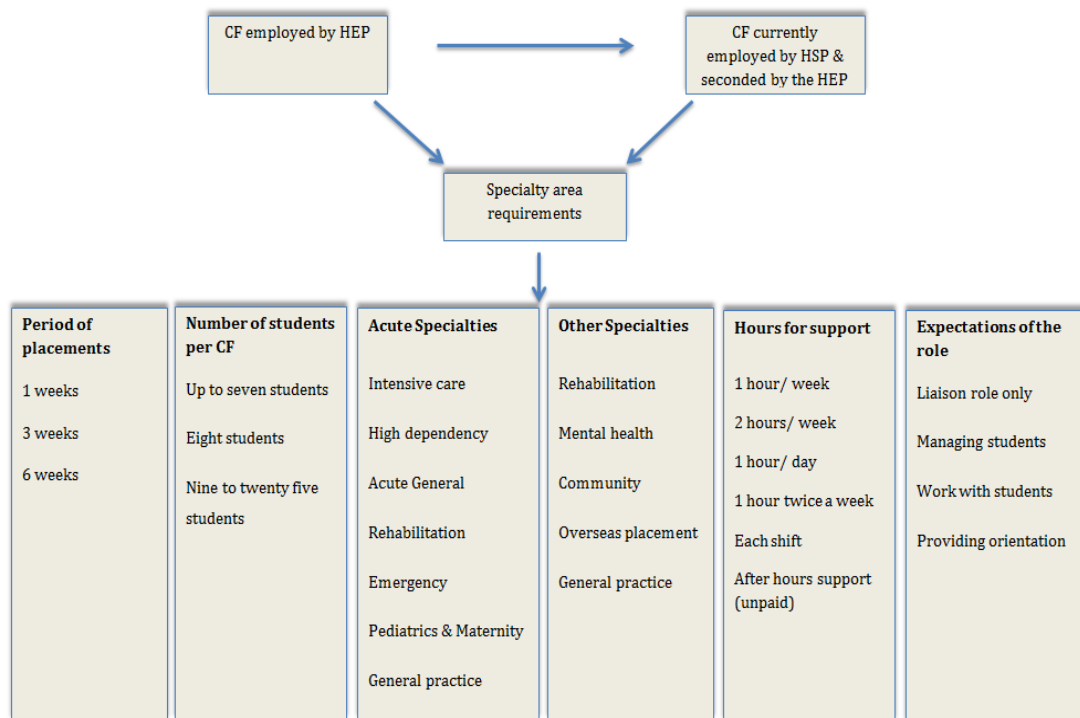


Figure 60: Variations of clinical practicums and support

Ida’s experience involved a dual role, where she was employed by the health setting as the undergraduate placement coordinator to facilitate student placement for all HEPs, as well as being employed by one of the HEPs to facilitate students within the health setting. Although Ida was employed by a HEP at the time to facilitate students, she continually spoke of facilitating students from the perspective of the HSP’s clinical placement coordinator.

First, Ida reported how the HEPs and HSPs employed and provided time for her to support students:

and [HEP#7] also used a **different model** of facilitation, as opposed to the other universities which have them working with eight students. With [HEP#7] I could have had, I think I had up to 25 (students) at a time. So, I did both roles, So I was the undergraduate placement coordinator ... The hospital pays me for the 1 day a week that I do, but they invoice [HEP#7], but it means that I look after **all their students on site** in terms of 24-hour contact ... **and also**, I was a support so if the **other** supervisors (meaning facilitators), the preceptors they **liked my role**, because **I had the ability** to be **remote** and to step in and **do all this one on one** ... I had the time to take the student away, had time to ask and get the information that I needed.

Ida valued this position and perceived that it provided excellent support for students. As Ida had an office, it gave CFs a place to come and discuss issues with her. In this role, Ida considered the staff benefitted as she was able to remove struggling students from the clinical area for debriefing.

Harry provided his insight into why there may be variations in support time:

Some of them are an hour a day. Some of them are an hour a week. Depends on where they're being supervised ... Some of the metropolitan hospitals require someone to be with them the whole shift [HSP#20], for example, has someone there for 14 hours. So, they actually operate as a shift system where someone has actually to be there.

Harry was asked, 'When you're doing an assessment of work readiness, what's your process for doing your assessments?'. Harry looked confused and replied, 'What do you mean, doing an assessment?'. He did not appear to identify and assess risk but was reliant on HSS to identify and assess the risks.

Barbara reported that the expectations of the CF in specialty areas differed from that of liaising and working alongside the student:

depending where you go ... they see my role a bit different ... So, you know, some think I should be at the bedside working with the student **all the time**. Whereas in places like emergency, ICU, more acute care, high dependency, theatres, they **don't**.

They see my role to be the 'go-to person' ...that I'm there to facilitate. That I'm there to mentor the student, and on the academic side of it, and to clarify any questions they might have about a student's clinical skill.

Working alongside the students appears to be a different role from that of the liaison role.

Although the hours for support differ, some participants expressed concern that the amount of time they were given to manage students' issues was inadequate. Elly reported: 'I'm only employed for **1 hour a week**, which **personally, I don't think is long enough**. I think we need **more time** to do **our** own assessment'.

In summary, the 'Variations of facilitation models' sub-theme describes how the identification, assessment and management of risk differs between clinical settings. The arrangements agreed on by the providers influence what type of role the CF is expected to perform in the identification, assessment and management of student issues. The participants who worked alongside students or assessed students' competence for themselves perceived there was insufficient time to undertake this role.

The next sub-theme to be described is 'Variations of clinical supervisor models'. These differences relate to how students are supervised and supported by their RN supervisors within the health setting.

4.4.1.3 Variations of Clinical Supervisor Models

In this section, the narratives show how participants used various names for CSs; at times the terms facilitator and supervisor were mixed. One supervision model used to support students was the preceptor model, which was considered a nurturing type of model. Another model was the buddy, or supervisor of the day model where students had a staff member to supervise their practice on a shift-by-shift basis. For this study, the supervisor model of support is described using terms related to 'one allocated supervisor', 'two or more allocated supervisors' and the 'A-team approach: Transient buddies' (see Figure 61).

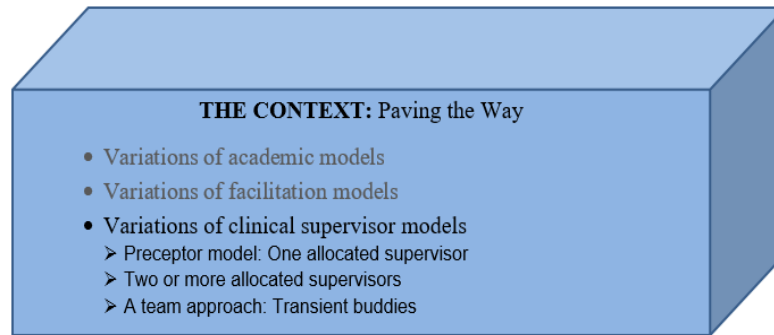


Figure 61: Models of supervision

4.4.1.3.1 Preceptor Model: One Allocated Supervisor

The ‘preceptor’ role is one where the RN takes on a role that includes teaching, coaching, supporting, assessing and providing a role model for the student nurse to follow. The preceptor provides feedback and suggestions to help the student obtain further learning opportunities and improve their practice. This model of support is illustrated in Figure 62.

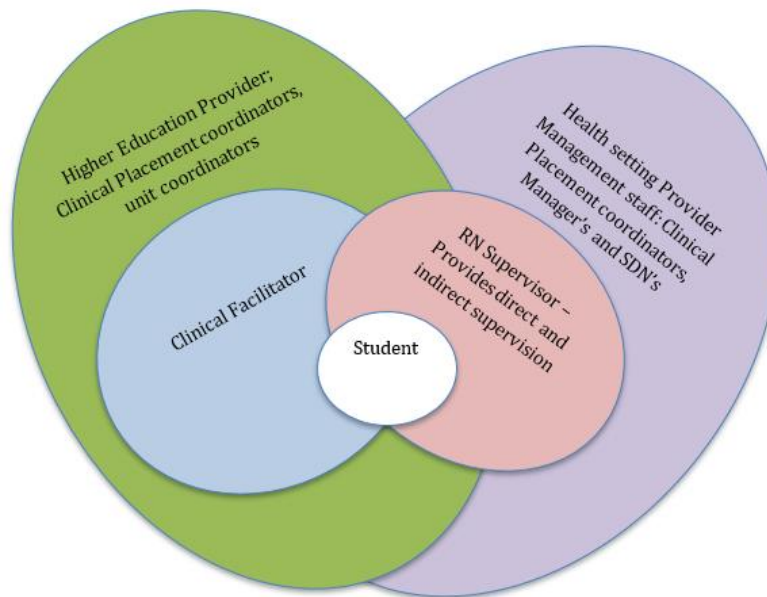


Figure 62: Preceptor model—One allocated supervisor - study findings

This model is described based on the participants’ perceptions about the advantages and disadvantages of support provided by one allocated supervisor. Barbara explained her perceptions of what the preceptor model of support was supposed to provide:

I am relating it to probably 10 years ago ... what I saw as the role of the preceptor ... as a student you would buddy up with your preceptor, and that would be your

person that you would work with, and you would do their shifts, and they would do your assessments often ... They would give **you feedback**, constructive and otherwise and yeah, they were there to help you **achieve** ... it was a relationship. ... if you go out and see students who have the same preceptor ... I don't know what the word is, they just **settle** and it is a much smoother **ride** ... they seem to be able to **relax** and **pick up** things a lot easier ... But I **don't** see much of it now ... I think its staffing, definitely staffing ... There, there doesn't seem to be a **solid staff base**; it seems to operate out of **chaos**, a lot of the time.

Likewise, Ashley explained how over a period, having a regular preceptor encouraged the supervising nurse to develop trust in the student's ability:

Whereas if they worked for the same person every day for the 3-week rotation that person will know **I can trust the person** to go ahead and do that and that assessment, or feedback will be reliable because I know the student ... **the students are let down. They think** they are going to be working with a preceptor for 3 weeks, but for whatever **reason**, it doesn't work out ... the preceptor shifts changed, or illness or something.

Some participants acknowledged mixed feelings about the value of the preceptor role. Debbie recalled having a student in a final placement in a '3-week rotation', who worked with her identified preceptor probably for around three shifts.:

It didn't work now, whether that's a good thing or a bad thing? It works both ways, [pause] because if you get a bad preceptor, and you've got to follow that person for the whole 3 weeks, that's not a good prac for you.

To summarise, the model where there was one allocated supervisor appeared to be a role that nurtured, assessed and gave students feedback, increased trust in the students and gave them the opportunity to be incorporated into the clinical team. This appeared to limit the risk to the student's ability to be ready for the role of the RN. Although this is a useful model, it can hinder students when they and supervisors have a clash of personalities. Success of this model is dependent on the quality of support that the student receives, and the CF needs to manage the risk when non-supportive relationships occur. The next model of support is where there are two or more allocated supervisors to oversee students' progress during the placement.

4.4.1.3.2 Two or More Allocated Supervisors

Because of the instability within the workforce, participants described moving from a set supervisor to a model where two or more supervisors worked with the student. Figure 63 Illustrates the support the student receives from two or more allocated supervisors.

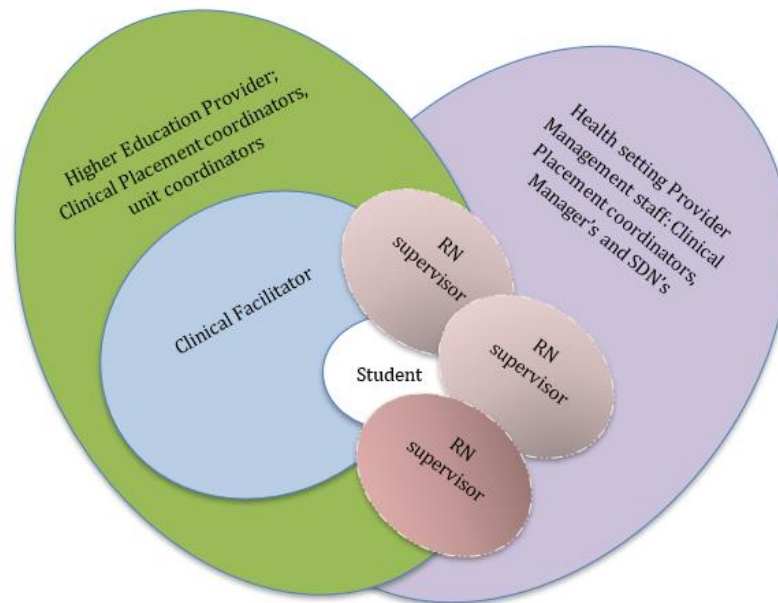


Figure 63: Two or more allocated supervisors

Debbie reported, 'You learn how different nurses work, and they're all different and they all do different things differently'. Having more than one RN supervisor meant that students would be exposed to a diverse way of undertaking patient care, which would assist a final-semester student to refine their techniques.

However, differences in nursing practice between supervisors were also seen to hinder student progression. Students could become confused about how to apply themselves to professional practice. Ashley reported that individual RN supervisors had 'a **completely** different set of **standards**, **completely** different set of, you know, **ways of behaving**. That throws the students!'. A consequence of this was that students might fail to demonstrate they could satisfy the expectations of the assessing nurse. These students would need to be monitored more closely by CFs on the impact of two or more allocated supervisors on student practices and their progression.

4.4.1.3.3 A team approach: Transient buddies

A team approach to supervision appeared to involve many factors that affected the identification, assessment and management of risk. This sub-element appeared to be an area that significantly concerned participants. Three sub-elements emerged as a result of the challenges associated with the skill mix of nursing staff: ‘Team approaches’, ‘Fragmented relationships’ and ‘Limitations for learning and assessment’.

4.4.1.3.3.1 Team Approaches

A team approach to supervision identified was the ‘team leader model’ where the team consisted of a RN team leader, a graduate nurse and a student nurse. This was an alternative approach to support the skill mix of the clinical area and increase the student’s opportunities to lead patient care (see Figure 64).

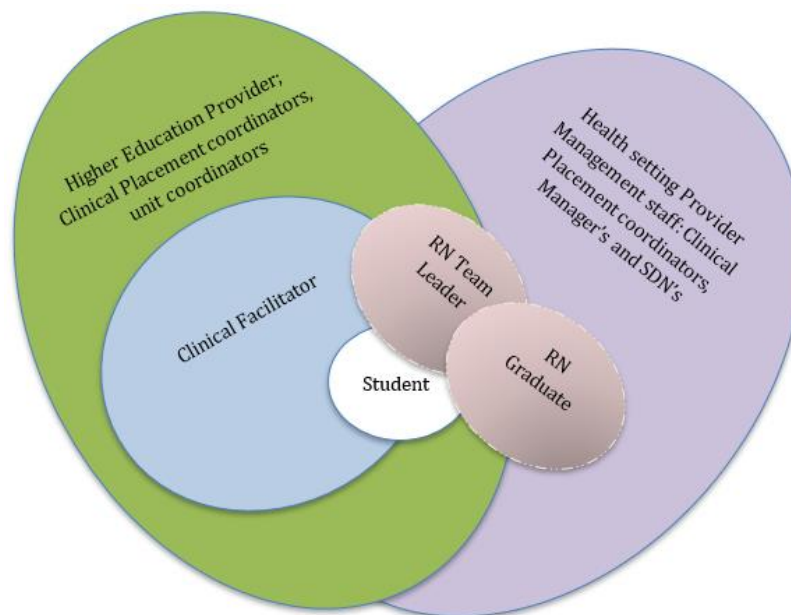


Figure 64: The team leader approach

Although most participants did not report on the use of the team leader model, Caroline had described:

You know, in [HSP#1] they had like a team, like two teams ... So, if they were on the am shift, they would come in and be with one team. So, say if there were four nurses on so two would be on that team, and two in another team. So, they would have different people um preceptor them ... so much better.

This model was perceived by Caroline as a useful model to support students on a final placement. However, the ‘buddy model’ was similarly used in the team approach to accommodate workforce issues such as not having enough consistent staff. Barbara reported that, ‘They don’t actually have a preceptor for every shift. So, they will have a nurse they work with, but it's not always their preceptor, and they don't work with the same nurse each shift’.

In contrast, Ida appeared settled and reinforced the trend of not having supervisors allocated to support individual students. Ida equated the term preceptor with the supervisor of the day:

You have to be very clear on what you call a supervisor, because what are they? You know. To me, a preceptor is to have a person for that day. It doesn’t mean that you keep that person ... the student should expect that they will have a different person every day. Cause most health services run on part-timers. People are sick; **people are moved.** You know **budget** constraints. One area might be really busy, another not.

This type of working relationship suggested that the supervisory relationship was transient. Although Debbie reported on the benefits of having different supervisors, she identified the need for students to spend at least a few days with the RN supervisor before having another supervisor. Debbie reported, ‘And I think it’s really good for students to see that [still tapping] **But they need to** work a couple of shifts **together** with that person’. This example indicated that the identification, assessment and management of risk might be compromised and that not all CFs liked this model. Figure 65 illustrates the participants’ perceptions about the risks and benefits of having transient supervisors.

Ida commented on what the expectation of the student should be: ‘So the expectation of the student should be “Fantastic. I’ve got someone for today”’. This example might suggest that workforce issues were influencing how students were supervised in health settings and indicate that students might not have had a supervisor. If students are not being supervised by any one specific nurse, they must be able to navigate the clinical environment to obtain feedback and assessment from members of the clinical teams in which they work. However, the relationships and clinical care of the clinical team members appeared fragmented.

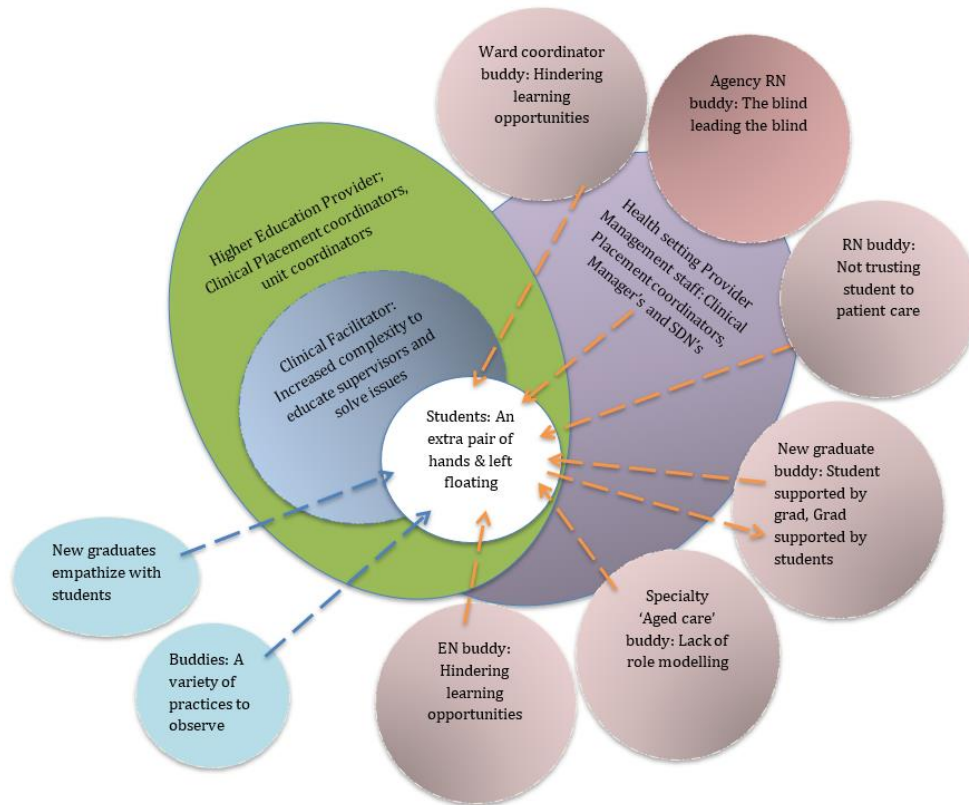


Figure 65: The team approach—Transient buddies with impacts

4.4.1.3.3.2 Fragmented Relationships

When inadequate staffing levels required agency nurses to fill staffing deficits, they could be placed to supervise students. Unfortunately, not all agency staff will be familiar with the health setting or specialty of nursing. Debbie worried about the risk of this to a student’s supervision: ‘I don’t think that’s good as they **don’t know that area**’. Elly similarly reported:

and they’ll say, ‘Oh, what’s expected?’. They have **no idea** of what’s expected. They’re not familiar with the paperwork, they’re not familiar with what the student can do. The students will be buddied with someone ... and if they haven’t had that continuity ... They **don’t trust students** ... Even though I’m saying they [the students] can they take a patient load, they [RN supervisors] won’t give the student an opportunity to take on a patient load ... because a lot of the time they don’t know the student, cause they might be an agency, or they’re not sure what students can do in different semesters.

This indicates that the transient relationship the agency nurse had with not only the health setting but also the student may have put the student at risk. When both the

student and their supervisor were new to the setting, it seemed as though the blind was leading the blind.

Barbara reported on the disadvantages when the student's RN supervisor was taken away from the student:

So to **have** somebody there that is a preceptor, that ... you get to know, you start to get to work out how you work together, and you are there for 2 or 3 days together, and then all of a sudden that preceptor disappears, and you have to **start** that bonding again with someone completely new who've you've got no **rapport** with whatsoever...

Ashley also found that a student who had a new supervisor was likely to struggle with being trusted to provide patient care: 'The student has **again**, got to build a relationship ... and has to **earn** the trust of the preceptor or buddy **every day**. Sometimes the RNs are **reluctant** to let go'. This example suggests that students who worked with different nurses each shift were at risk of not obtaining opportunities to provide total nursing care.

In summary, the transient nature of supervision is exacerbated by the demands of the workforce and by the skill mix of nursing professionals. A transient relationship is seen to affect nurses' relationships with students. Where rapport and trust is not developed or nurtured, students appear at increased likelihood of not being given opportunities to practice.

4.4.1.3.3.3 Limitations for Learning and Assessment

This sub-element identified how participants viewed the team approach as limiting a student's opportunities for learning and gaining appropriate assessments. Elly reported:

The staff member that is senior is coordinating ... there is no one else to, to buddy them up with ... I think **that is a big risk**, of **not** allowing the students to get the **most out** of their placement ... They will buddy them with an enrolled nurse so that they [students] then **can't do** medications and they [students] **can't do** certain things ... I had an enrolled nurse that was ... final semester and the feedback from the student was 'I **feel** that I'm here to **support** the graduate nurse, **rather** than the

RN giving me anything' ... That was **hard** for me to hear ... she should still be getting the **most** out of her clinical placement.

Being buddied up with the coordinator of the ward or the EN appeared to be problematic for experienced ENs who were transitioning to the role of the RN. As the transitioning EN was expected to upskill and increase their ability to make decisions and to delegate care, the supervisor who was also an EN would model the behaviour of the EN and not the RN. The transitioning EN student may already have advanced skills with medication administration and yet is not allowed to give out medication with a supervising EN. In these circumstances having an EN supervisor could limit the student's ability to demonstrate their medication ability or their time management in the administration of medication. Although workforce factors dictated which staff were available for student supervision, Elly still had to provide opportunities to extend the professional development of her students.

Barbara recounted the effect of having inconsistent buddies:

Students find it **very difficult** having a different staff member **each** shift ... **no consistency**, there's **very little consistency** when it comes to buddying up with students. And I think for students, it's like being in a **boat, thrown** in the middle of an ocean. You know, it is a **really unstable** environment for them.

This narrative indicates the student was left drifting. Consistency appeared essential to the identifying, assessing and management of risk. Without consistency the student was likely to be at greater risk of not becoming ready for the role of the RN. In some instances, students did not have anyone assigned to them and this indicated that the risk to readiness was increased. Debbie reported that students felt isolated if they were not provided with an RN supervisor at the commencement of the shift:

If they [the students] haven't been given a preceptor ... they don't know what patients they're going to be looking after, and they're sitting there thinking, 'Well, who am I going to go with?'. And that makes them feel as though they're really wanted, you know.

This reflection suggests that the integration of students into the team was somewhat fragmented. Ashley raised concerns about how ward coordinators burdened their staff who were supervising students with heavier nursing care duties. She reported:

It **seems** as though the student is seen as a pair of hands. ‘Yes, I will have a student today because I have a heavy load’ ... when the coordinator does the allocations, they go ‘Oh good, they’ve got a student, we’ll give them a harder load’ ... Aged care [pause] ... so there is a lot of AINs or carers, and ENs, and I find that they are not as **assertive** or forthcoming, and they don’t understand the role and **responsibilities** of a registered nurse. So, their **assessment of** a final undergraduate semester student is **not accurate**.

The identification, assessment and management of risk to the readiness of students appeared to be undermined by these attitudes. In the aged care setting, students would initially undertake resident care with an AIN who performed basic tasks such as showering and transferring patients. The EN performed tasks requiring higher levels of clinical skills such as wound dressing. However, it was the RN who must manage the delegation of care to ENs and to carers, and communicate with pharmacists, doctors and family members about emerging issues pertaining to resident care.

In summary, the participants had varying responses to how models might or might not benefit students in their final placement. The quality of support appeared more significant than the model that was used. However, the team approach was transient. Relationships and opportunities to practice appeared fragmented. The transient nature of the CS’s role hindered the development of rapport, the building of trust and the appropriate modelling of practice and behaviour.

The next sub-theme covers differences in how nursing care is delivered by nursing staff to patients, and how the participants perceived that this affected a student’s ability to be ready for professional practice.

4.4.1.4 Variations of Patient Care Models

There are a variety of models of patient care, including a task approach, a team approach and a holistic or therapeutic approach. Sometimes a mix of approaches is used. The appropriate model of patient care is one that will meet the needs of the patient, the needs of the workforce and the needs of specialty nursing care. The four models depicted in Figure 66 set out the participants’ lived experiences with ‘Using patient allocation’, ‘Using the team approach’, ‘Using the task approach’ and ‘Using specialty approaches to nursing care’.

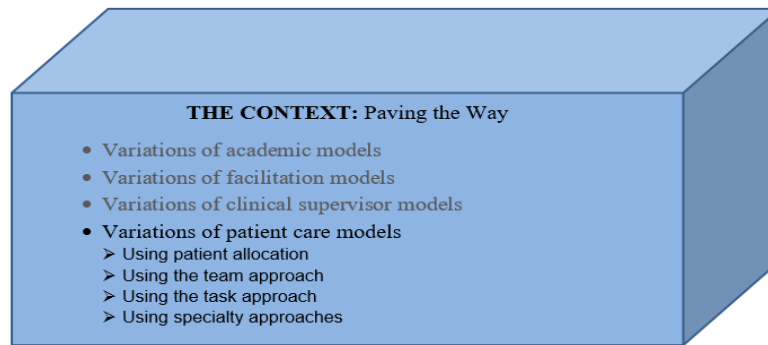


Figure 66: Variations of patient care models

The approach to patient care was seen to either support or hinder learning opportunities to manage patient care. The effect of these approaches is illustrated in Figure 67.

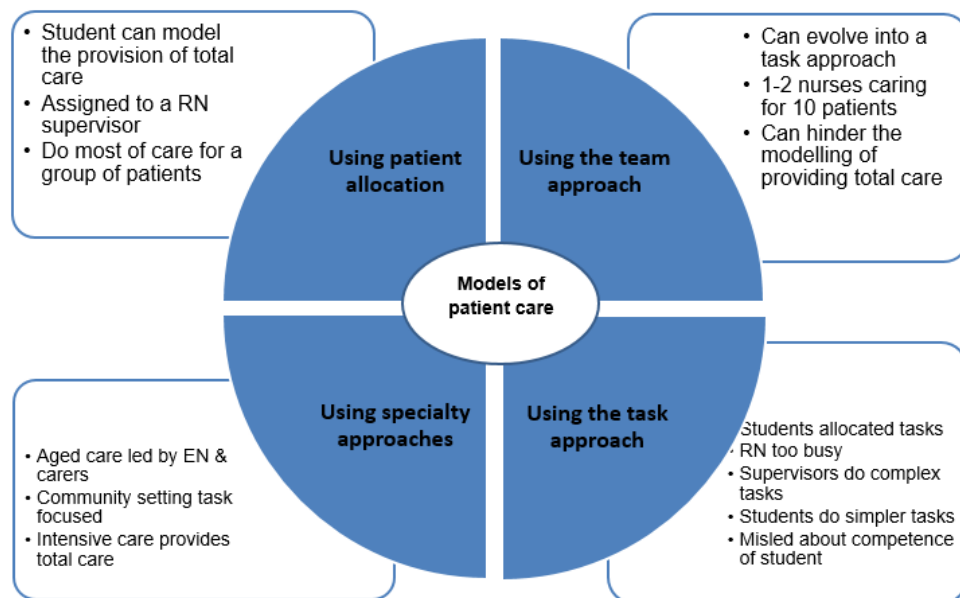


Figure 67: The effect of patient care models

The participants described their expectations for students when they were providing patient care during final clinical placement. The first model described is the patient allocation model.

4.4.1.4.1 Using Patient Allocation

Fiona revealed that she expected students to approach patient care utilising the therapeutic, holistic or total care approach. In using this model, students were assigned a caseload or group of patients for whom a RN was expected to prioritise and coordinate their care, as Fiona said:

They all have a mentor or are assigned to an RN they work with, and they go about initiating their work, and the RN oversees them. They do the bulk of the clinical work; they're assigned two or three patients ... in the second week.

Debbie identified that some HSPs demonstrated to the students a holistic approach to providing patient care:

It's holistic, they **don't do** team nursing at [HSP#6] ... and [HSP#5] either ... it's more of a one on one and, **they get their patient load and they're expected to look after all of that**; except when they do their medications they will get their preceptor in to supervise, and if they need pain relief, they will need to get their supervisor to do that.

In this model, all the patient's care was attended to by the student, which helped the student to comprehend and provide nursing support. When needed, the supervisor would directly supervise students when undertaking specific types of clinical skills required for care and that were in line with the student's level of learning. The next model describes the use of the team approach.

4.4.1.4.2 Using the Team Approach

Other participants identified that the team approach was a standard way for students to meet the requirements for managing patient care. Ashley reported: 'The model of care is a **team approach**, so one or two, two staff will be assigned to a group of 10 patients'. She reported that she struggled with certain aspects of the team approach as students could not be assigned a group of patients to provide total nursing care:

I am really struggling to get her [one of her students] to take on a small patient load this week. It is something that she should be aiming for. She finds it difficult because there is a team approach and that, um, autonomy if you like, or, at least, coordinate the care of two patients is difficult for her to do in that environment.

The coordination of two patients might not necessarily have matched the normal requirement of RNs to manage a case load of four to six patients, and indicates that the student may have struggled on registration to manage a larger case load of patients.

Ashley reported on how a team approach focussed on the tasks that needed to be done:

A timeline is placed ... on a trolley in the middle of the corridor, and across that timeline are **tasks assigned** to each room, and the staff achieves their workload by ticking off the **tasks**, and they are, very **task, I think very task orientated**.

The team approach was seen to merge into that of being task focussed. A focus on the task increased the risk that problem solving or decision making may not be incorporated or recognised by students or assessors. This lack of understanding was likely to undermine confidence upon commencing employment using approaches using models of the team or of patient allocation. The task-centred nursing approach is further explained next.

4.4.1.4.3 Using the Task Approach

Participants perceived that the progress of students was limited when students or nursing teams did not provide care with a holistic view, but instead undertook nursing tasks. Elly, who had experienced similar things to Ashley, emphasised:

[Students] don't get the most out of the situation ... if staff members are so busy ... having a student is time-consuming ... [They] will get the students to do ... all the observations ... all the showers and then they [the RN supervisors] will go and do the more complex things themselves.

According to Elly, students in their final placement:

want to be learning new dressings. They want to be learning the medications. They want to be experiencing the things that they haven't had a chance to do ... Well, I **do** think it's significant if they **can't** learn how to coordinate and prioritise a workload. It is really **basic** to their **beginning** life as a graduate or new graduate ... the student **thinks that they've managed their time**, and they've **managed** and the days gone okay, but they're **all of the things** that the staff member has **done** behind the scenes that the student is totally unaware of.

To become ready for practice students will require the experience of prioritising and coordinating care. Unfortunately, the task approach did not always allow the students to practice as they wanted. They needed their RN supervisors to provide them with the opportunities to prioritise and coordinate care. This narrative indicates that students could be misled into thinking they were ready for professional practice. Staff who also

considered the student had completed the tasks as asked were also likely to view the students as obtaining readiness for the role of the RN. A further factor that could influence the delivery of patient care was how specialty areas provided unique approaches to nursing care.

4.4.1.4.4 Using Specialty Approaches

Throughout the narratives, participants mentioned specialty areas in which students had undertaken nursing practice. In an intensive care unit (ICU), nurses usually have one patient to care for; an acute setting might allocate nurses with four to six patients; while an aged care setting might have an RN managing a caseload of 60 residents as well as managing care assistants and other staff members. For each specialty area, the approach to patient care is defined by the specific approach needed for the specialty area.

Ashley reported on supervising a student in a community setting:

They didn't **ever** get the opportunity to **manage** a group of patients. It was one patient at a time, one visit at a time, so they weren't able to **practice** their time management skills ... Very much led by the **RN** who is out there!

She had considered students were limited in managing complete patient care in a community setting as the delivery of patient care was led by the supervising RN. In this specialty setting, students may have seen patients either in their homes or in the community's healthcare clinic. When providing nursing care to individuals in the community, the RN and the student visit a group of patients throughout the shift. This indicates that more information about how the community supervisor was identifying, assessing and managing the student's readiness for the role of the RN is essential to understand how competency and readiness was achieved.

Caroline's specialty area was theatre and she had also supervised students working in an aged care setting. She considered that working in aged care was simple to learn:

I find this a lot in aged care. It only takes 2 days to know aged care you know ... like in the hospitals and all the places or facilities [they] tend to use the staff [students] as **FTEs** [full-time equivalents].

However, the variations of managing residents instead of patients and practising the delegation of care to non-registered carers was not mentioned. Each specialty area utilises approaches that outline how to manage care. This narrative indicates that more information about how assessment and management of a student in the aged care setting during a final placement is necessary.

In summary, four models or variations of patient care have been described. Three of these approaches were perceived as more likely to increase the risk to students of not being prepared for professional practice. Students who utilised the patient allocation approach were more likely to be seen to be meeting the expected standards for prioritising and managing patient care.

The findings of the theme ‘The context: Paving the way’ are now concluded. The next theme describes the background experiences and values of the participants as ‘The context: The clinical facilitator’s toolbox’. This concept describes what ‘tools’ the participants used to steer the student on this journey.

4.4.2 The Context: The Clinical Facilitator’s Toolbox

The second theme describing ‘The context’ of the participants’ toolbox refers to tools that participants used to support students in their learning and tools that described the background and attributes of the participants. Although this section reports on the participants’ toolbox, all drivers (HSS and students) also had backgrounds and attributes that influenced their behaviour and attitudes, and these are also described throughout the phases of the journey. Barbara stated:

Yeah, look, I suppose if you run out of your own, you have to be able to see what everyone else is using. You know. So, if the tools you are using are **not working**, you got to see what else does work. You know what I mean? It’s like, I don’t know. It’s like if your car is on the side of the road and you’re trying to fix it. If you **don’t have the right** tools, then you need to go and see what you need. And I think that depends on **how** serious you are or committed you are as the facilitator.

The sub-themes that emerged in the toolbox of the CF participants are: ‘The clinical facilitator’s guidebook: Familiarity and background’ and ‘Using high beam: Important values’ (see Figure 68).

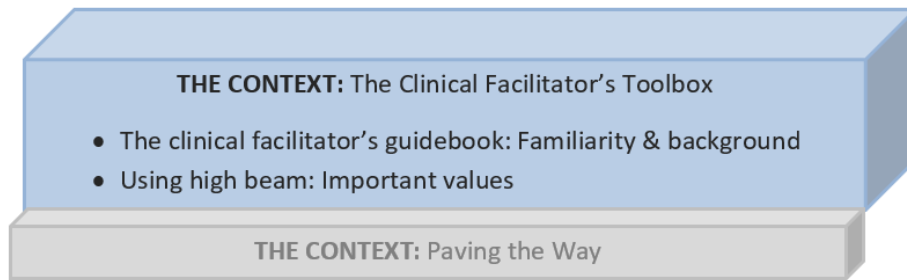


Figure 68: The context: The clinical facilitator's toolbox

4.4.2.1 *The Clinical Facilitator's Guidebook: Familiarity and Background*

Central to the toolbox is the participant's experience, knowledge, preparation and relationships that they have forged with others. The guidebook describes the previous experiences of the CF that influenced how they undertook the identification, assessment and management of students and how this influenced their behaviour or attitudes in managing a student who was struggling. There were four elements identified: 'Background of working academia', 'Background of knowing students', 'Background of knowing health service staff' and 'Background of clinical expertise' (see Figure 69).

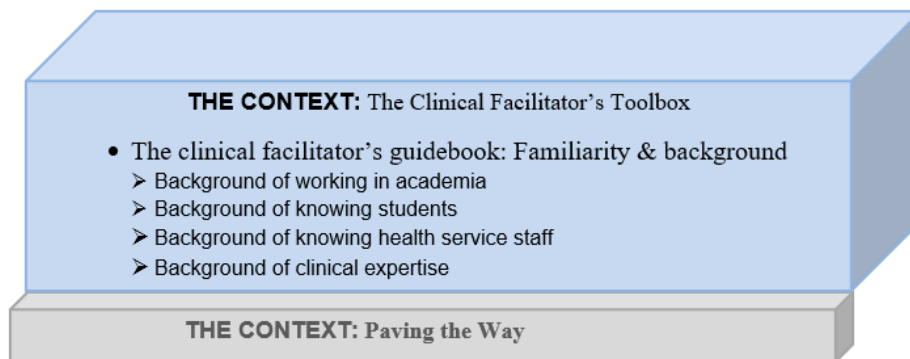


Figure 69: The clinical facilitator's guidebook: Familiarity and background

Figure 70 outlines how having familiarity and background with these concepts affected behaviour and attitudes of students, supervisors and CFs in regard to the ease with which they could support students.

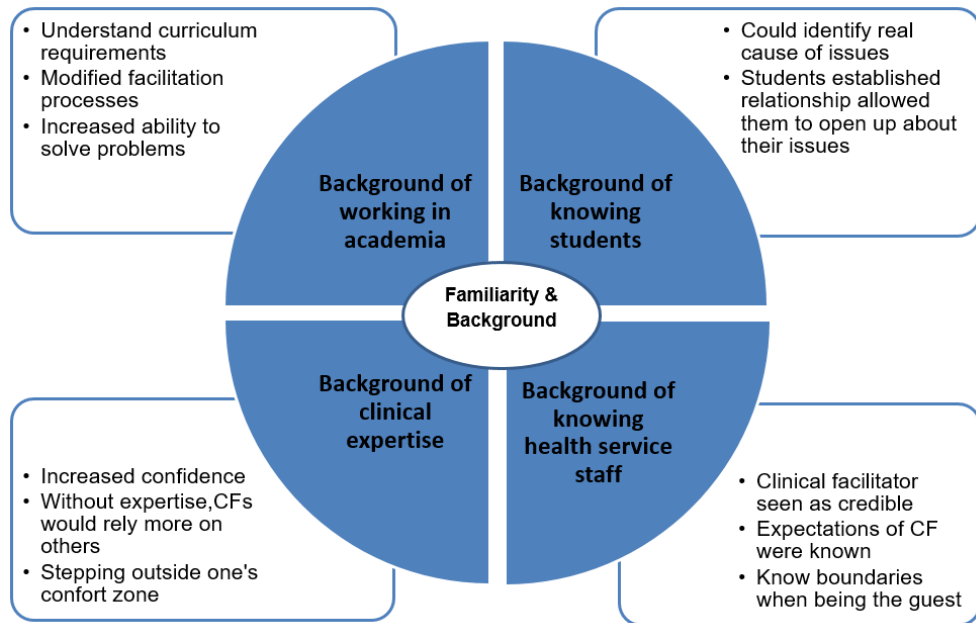


Figure 70: Effect of having familiarity and background

4.4.2.1.1 Background of Working in Academia

Having familiarity from an academic perspective opens the worldview of the CF, assists them in modifying their facilitation processes and improves student readiness for practice. Having a working history supported the CF when assisting students. Knowing how students were taught and understanding the nature of differences in the workplace were identified as enabling factors to better support students. Within this theme, participants identified developing a familiarity with the facilitation role and benefits of university teaching experience.

Participants identified that facilitating a range of students over time increases perceptions about their self-efficacy to manage student issues in clinical practice. Gemma reported: ‘Yeah I think it just made me a little bit more certain in dealing with things, the way they need to be dealt’. When she first started, she did not have the experience and when problems arose she would approach them by saying, ‘Yeah, we will wait for week 2 and see how they go, she’s just settling in’. Experience had influenced how she would now manage this. She reported: ‘Like if I know, there’s potential for concerns I get on top of it straight away ... and yeah I think now if you pick up on day 2 you just act on it instead of waiting’.

Working within the academic setting was linked to opening up the views of the participants. Elly had worked in the academic setting as a tutor. Her primary role was teaching clinical skills. She reported that having worked within the university had given her an advantage when facilitating and supporting students: ‘I am at an **advantage of knowing** what’s taught in the lab ... If I **didn’t know** what they had learnt in the labs, I wouldn’t be as understanding to that’. Knowing where these differences occurred between health setting practices and the theoretical or psychomotor skills taught within the university laboratory setting allowed Elly to ‘have an open mind and I am not as strict as I used to be on you must do, do it this way **otherwise you’re going to fail**’.

Harry’s expertise was in mental health and he reported on his current expertise and how it was used to improve student pedagogy and preparation for the workplace:

So, I kind of have a good idea of what is currently required ... when they qualify. Especially those who work in a mental health setting ... to go between the theory, the theory for me has to be what they are going to see out on prac.

He showed that he valued adequate preparation of students before they entered the clinical area for practice. By making these links between theory and practice, this participant further clarified how effective these changes were considered by HSS in moving students forward for the RN role.

In summary, having a background of academia was seen as beneficial to understanding the goals students needed to achieve on their final placement. Having clinical expertise was also seen to benefit students, so that HEPs could then prepare them better for the role of the RN. The next background tool that was significant to I, A & M risk was the background of knowing students.

4.4.2.1.2 Background of Knowing Students

The CFs who were familiar with a student had greater insight into the student’s issues and this insight helped them to identify the real causes of issues. This familiarity also increased the open communication of students with the CF. This familiarity with the student was established before the commencement of the student’s clinical practicum. In the experience narrated below, this familiarity was based on knowing the student’s

background and characteristics. It was believed that as these relationships were established, it would be easier for the student to be transparent about their issues and to seek support. Harry reported:

With regard to mental health students **specifically**, the um, I already have that relationship with them cause I've taught them for a year. So, while I might not know all their names, I certainly know all their faces and their personalities, and I **know** who have been to lectures. I've seen them in tutorials, exams, so by the time they go into prac I already have a relationship with them.

Participants who were lecturers or tutors within the university setting and who might have facilitated students out in practice perceived they were more prepared to manage the student's progression. Similarly, participants who had not worked with students within the university as a lecturer or tutor, but who had worked with them on a final placement, perceived this was beneficial to them in facilitating another cohort of students. Ida reported how her familiarity with the student paperwork assisted her to step easily into the role when liaising, to support students:

So, I was the undergraduate placement coordinator ... when I worked with students, I was very familiar with their paperwork, what they needed to achieve, how they were going to achieve, the objectives they needed to achieve. So, familiarity with paperwork makes it easier to understand where the students are coming from and what they need to do.

In this next narrative, Elly related an experience in which she had previously known and worked with a student:

You **have to have more experience** to know all those things that **impact the outcome** ... It was nothing to with work. It was to do with her personal situations, um, but it was only because I **knew** what she was **like**.

The participant was able to piece together a mismatch between the current behaviour of the student and their behaviour from the previous placement. Having this prior knowledge of the student was highly valued and implied that an established relationship would allow the student to open up about their issues.

In summary, the background knowledge and experience of academia, facilitation and students assisted participants to deal with issues. This aspect of the CF's toolbox is

essential for dealing with the risks of unreadiness. Another beneficial background identified was familiarity with HSS.

4.4.2.1.3 Background of Knowing Health Service Staff

RNs who were employed by the HSP and seconded by HEPs to facilitate a group of students were more easily trusted and given credibility. Ida reported on the benefits of working within the health setting and how the culture of the health setting influenced the acceptance of the CF:

Cultures are very different and how the hospital or the organisations see its staff ...
I **do think** that having the supervisor or the facilitator come from **that area** is more beneficial. Cause they have those relationships.

Similarly, another participant believed that having had a previous working relationship with the RNs in health settings as a theatre nurse had benefitted her students. This established relationship assisted the CF in being trusted and considered part of the team to support students.

Ashley also reflected on the value of having sustainable and trusting relationships with HSS that would sustain the process of effective facilitation:

It's an **advantage to me**. I don't have to **continually** have to build those relationships ... as I said, I deal with **most of my supervision** at [HSP#4], so the staff at the hospital **know me** ... and that **build-up** of relationships **within** the hospital, **within** multiple wards settings, to me **advantages** the student ... they trust you to talk to you about issues with students, and vice versa. And that relationship is built before the student even gets there. And the expectation and my expectation is known by that hospital.

Having a working history or a teaching history connected to individuals or teams within the health setting was also seen to build trust among participants, RN supervisors and students. Regardless of the model used, all drivers were expected to be part of the team that helped students to develop.

However, recognising boundaries appeared to be important for participants. Fiona referred to both herself and the students as guests within the health setting: '**We're guests here**, and we have to behave as such'.

In summary, being familiar with HSS improved the participants' ability to have better relationships with them. Better relationships meant having rapport and being trusted. However, participants had to work hard to establish rapport and needed to be aware of their professional boundaries. The next element describes the benefits of clinical expertise.

4.4.2.1.4 Background of Clinical Expertise

Specialty areas include areas of theatre, ICU and community health. However medical, surgical, rehabilitation, maternity, paediatric, mental health, overseas placements and general practice areas are also specialty areas that focus on specific aspects of nursing. Another specialty placement used for a final placement is that of an overseas placement. In this setting, two or more facilitators supervise a group of students. The sub-elements identified were 'Familiarity and confidence' and 'Unfamiliarity and impact on reliance and confidence'.

4.4.2.1.4.1 Familiarity and Confidence

Barbara identified that when she was an inexperienced CF, she did not know the expectations for facilitating students:

It's **hard** when you're starting out ... when they are sort of thrown in **without** the experience ... because they [CFs] don't know what the expectations are and so that's when I think that things can go wrong.

Barbara also admitted that she had 'learnt over the years, and I know that's **awful**, but **I never, I got nothing from nowhere**. I've made it up as I've gone along'.

Fiona illustrated how she had the confidence to facilitate students as she had the expertise and history of working as a facilitator for some time, as well as having had the experience of working as a midwife: 'Look I am quite **confident** that in my ability to, um, you know carry on, to carry on as clinical nurse facilitator because I've got the skills. I'm a midwife as well'.

It has been established that facilitation processes increased the confidence of participants to undertake their role. However, a further risk to students becoming prepared was when HSS did not welcome students and the CF did not have the

expertise to guide students. Caroline reported, ‘I was told **day 1** when I first went there, they don’t have time for the students. We have too many of our own to deal with’. Caroline, who was a theatre specialist, considered that where students were not wanted or supported by HSS in theatre, ‘It is **imperative** that you [the CF] **have** a theatre background ... **You just couldn’t do it** if you were not a theatre nurse’.

Harry reported that on an overseas placement, students should have a general knowledge base:

A combination of, they need to have a good all-round knowledge base and to be honest, when you do those pracs overseas they are a combination of primary care, surgery, um. We go to paediatrics, all sorts of stuff.

This reflection indicates that CFs would also need to have knowledge and practice that was general across a variety of specialty areas. Although good all-round knowledge appeared essential in some instances, in others, specific knowledge was essential; the confidence to undertake the identification, assessment and management of risk was increased if participants had specialty knowledge. The effect of not having familiarity is now described.

4.4.2.1.4.2 Unfamiliarity and Impact on Reliance and Confidence

Ida considered that although she was not the expert in theatre, she could rely confidently on the supervising nurses to determine if students were ready for practice as she had familiarity with the HSS. She reported:

I think that there are areas where yes you can see the students and talk about their experience and maybe in theatres where like I’m not the expert, but I still facilitate them very well, because of my relationship with the SDNs [staff development nurses] and with the preceptors in a secondary way, I am getting that information.

In her liaison capacity, although she was familiar with HSS, Ida had relied solely on the feedback and assessments of her professional colleagues and was less active in identifying, assessing and managing of risk.

In Ashley's first interview she described the liaison role as using telephone support with the staff in a community setting. She struggled with this method of trying to build relationships with HSS and students:

That type of relationship, over a telephone in the community setting ... I **wonder** at the value of it, **apart** from being a liaison from the uni ... very **difficult to supervise** somebody that you **have never met, over the phone**, in a setting that I am **not familiar with**.

Ashley did not have confidence that her liaison role would be a supportive role and indicated that she felt uncertain about the outcome as she was not in control of the identification, assessment and management of risk. After Ashley's second interview she reported that the liaison role with telephone support was not as useful as having a physical meeting with the student and staff:

No not as good as face to face, and **I didn't enjoy** it very much. A lot of it was just straight question and answer. Where at least when you **with** a student, you can **see** where they are at by their body language. Probably only once a week that I speak to somebody, and that is **usually** that was because they would answer the phone, I would ask to speak to the student and ask for feedback. But sometimes I **found** it a little disjointed. Because I **wasn't always talking** to the same person ... on the **telephone** some of them were **quite vague**, 'yes she is doing well', 'yes **she's doing fine**', 'I will go and get her'. [laughing] I would usually **only** explore questions if it comes up or **if I** am unsure of the student's practice. And **again much easier to do** when you are looking at their documentation, or watching them interact with patients. Much easier than this telephone business. Really, it felt more like it was just the uni checking up.

Ashley valued the role of being physically present with the student to I, A & M risk; utilising a liaison role with telephone support appeared to limit her ability to take control of the identification, assessment and management process and had increased her uncertainty about how well the student had progressed. Her laugh had sounded more like a scoffing sound and indicated that nurses did not want to speak to her.

Elly also lacked confidence in supervising students outside her specialty areas. She was asked in her first interview, 'Have you covered students in theatre?'. She reported, 'No, cause that's not my specialty, so it's all right, **I wouldn't** feel comfortable in

theatre cause that's **not my specialty**'. However, Elly reported in her second interview that she did supervise students within the theatre placement. She found that taking the risk and stepping outside of her expertise was effective if she had the support of expert nurses within the specialty area:

I did feel out of my comfort zone, and I **really had to build** a good rapport with the staff development nurse ... It was not my normal role there ... but **thankfully** the staff development nurse was as good as she was.

The SDN had the confidence, time, skill and willingness to liaise with Elly. Here the SDN was pivotal in increasing Elly's confidence that HSS were managing the student:

I was just **really lucky** that the staff **nurse was lovely and was fabulous** and was confident to meet with me and fill in all the paperwork, whereas if I had had a staff development nurse, (pause) cause, some staff development nurses **don't want anything to do with the paperwork**.

In this narrative, Elly showed that she needed to rely on HSS to manage student progression and she acknowledged that she was 'just really lucky' to be liaising with that particular nurse. However, luck was not always present when relying on others to I, A & M risk to student progression. When participants had deficits in familiarity with the specialty area, there appeared to be an increased reliance on HSS to assess and manage student development.

In summary, not having experience meant that participants would need to rely on others to I, A & M risk. However, the benefits of being familiar with the clinical specialty meant participants were more confident. When students were not wanted by HSS, CFs needed to have specialty expertise to assist and support student learning. An additional tool of significance was the values that drove participant support.

4.4.2.2 Using High Beam: Important Values

This sub-theme describes what participants felt were key values that assisted all drivers to steer the student towards readiness. These key values were at the heart of how the participants described their role of facilitation, formed part of the participants' toolbox and appeared central to their actions. The first value identified is one of transparency: visibility and accountability, openness and honesty and fairness.

Participants also valued the nurturing role. Figure 71 illustrates these values as situated in the CFs’s toolbox.

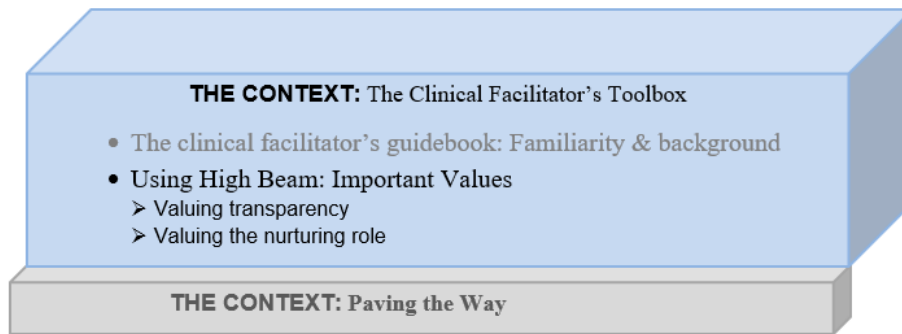


Figure 71: Using high beam: Important values

Likewise, participants reported on their CF colleagues and also HSS who had deficits in showing transparency. Figure 72 shows the effect of these values and attributes that participants believe would hinder or enable student readiness.

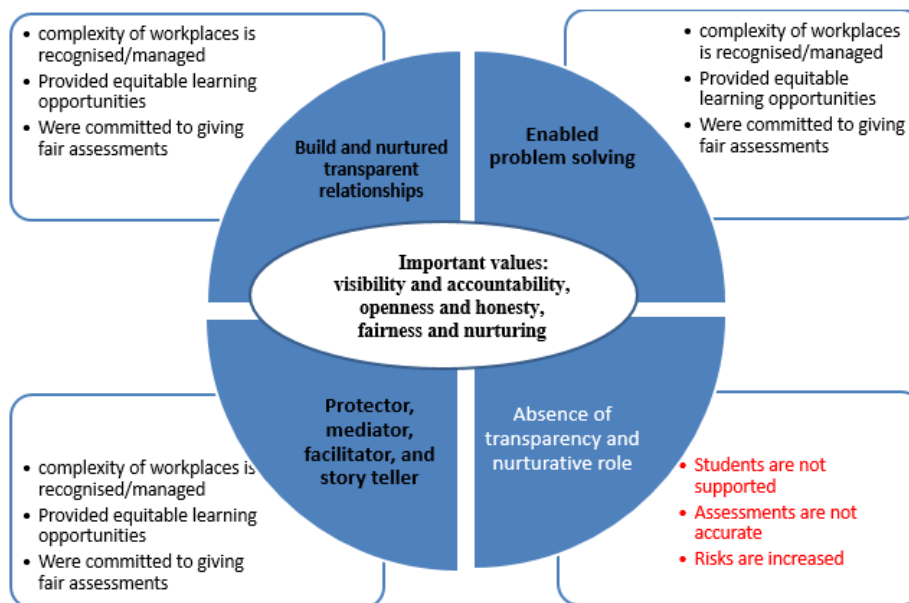


Figure 72: Effect of using important values

4.4.2.2.1 Valuing Transparency

Transparency included the valuing of visibility and accountability, openness and honesty and fairness. All participants expressed that having visibility and accountability were key values or attributes that were important to them and were important for building and nurturing relationships. Participants described the effect of transparency: ‘Being transparent’ and of ‘Not being transparent’

4.4.2.2.1.1 Being Transparent

Valuing transparency was reported by participants as valuing visibility and accountability, openness and honesty and fairness. Ashley reported:

Not only being transparent but being visible ... I think that it's very important to be visible **in** the hospital **on** the unit. Whether it's just interviewing the student, I think it's a big part of being interactive with facility staff. That's how I have built my credibility in the facilities.

Barbara reported on how she was conscious that her behaviour was visible to students:

I know that I am being watched they will listen to everything I say, They look at how I come to work, how I present myself, you know my dress, how I present my time management ... so that when **they** graduate, they see that it's part of their role to educate, not with the patient, but with other staff ... that we look after, and we mentor, and we facilitate learning for our colleagues, and for each other.

Implicit in this comment is the value of the nurturing role towards students and of other nursing colleagues. Barbara also commented on how she would be transparent and accountable with her students from the beginning of the placements:

It is a **very** transparent conversation ... I **actually set up** how, or what they need to do to pass, also **what will happen**, or, what a fail **looks like**. If I know that a student has had a clinical incident previously ... then I can get an understanding as to the background of how that happened or why that happened. And then we sit down and talk about a plan ... It is **being honest with the student**. So if there is something that they make a request, or they **want** something and it's **unachievable**, or it's not going to, you know, just not within the resources of the hospital, then I think instead of saying 'oh yeah, we can do that', it is actually being honest and saying 'we can't do that. So how are we going to work this out?'.

This transparency commenced at the start and assisted both the student and participant to identify and manage issues related to not only the student but to the workplace. In turn, she expected that students would open up and be honest about the issues they had experienced so that students could continue to progress and be given opportunities to develop.

In providing opportunities for learning, Caroline valued a sense of fairness. All students should have the same opportunities to learn and practice in different areas of a theatre placement. Caroline reported: '**each one of them** ... the seven students in the end ... **all had that experience**, each time'. Elly also reported on fairness being an attribute she valued when obtaining biased feedback from HSS. She reported: 'So I think it's fair that whatever feedback that I get, I **want to see** for my own eyes, to be fair to the student'.

4.4.2.2.1.2 Not Being Transparent

Participants also reported on the effect on students of not being transparent, and of the CF being absent. Ashley sounded appalled when she reported on seeing a lack of accountability and visibility from other CFs: '**I know** too that there are facilitators that walk in, see their students, sign off the entries or whatever and leave again, and **don't spend the time** that they are **supposed** to spend'.

This implies that students were more at risk of not being adequately supported to develop professional competency. Similarly, Ida reported the discovery of a CF who did not spend the required time to support students:

I had one particular supervisor or facilitator ... who looked after ... different unis, ... she was ... coming to get them to see her in her lunch hour ... or she'd pop up for 5 minutes and write up **45 minutes** she'd seen them for.

This narrative indicates that the CF was functioning in an unprofessional and unethical way. Not keeping track of student progress and safety to practice was likely to result in a greater reliance on HSS to pick up and then report on these issues to the HEP.

Elly reported on HSS who did not trust facilitators or wanted to protect students from failure: 'I honestly feel that that's more of an issue ... To trust you and to feel that they can come to you and be honest and open with you'. Not having staff be open and honest about a student's development appeared unfair to the student as the CF was less able to assist in directing or guiding the student onwards.

4.4.2.2.2 Valuing the Nurturing Role

Most participants related to themselves as being ‘mother like’ and indicated that they valued being the nurturer. Terms to describe the nurturing of students were linked to that of being the model, the admonisher, the protector, the mediator, the facilitator and the storyteller. Fiona reported:

I think it’s **how you groom them**, how you **treat them**, and I think our role is like mediator ... you sort of mother them a bit. Well, at especially my age we become like a little family for the 3 weeks. We eat together ... We do jobs [and] I have to reassure them ... I’ve got a lot of knowledge that I can impart to them so that when they ask questions, I’m usually able to accommodate them, and then I tell them stories of my career, and they like this too.

Debbie linked the facilitation role to one of problem solving and facilitation:

I’m like a mother ... I’m there to facilitate your ... prac. If there’s anything there that goes wrong, **I’m there to fix it!** That’s how I view me being a facilitator ... **I’m like a mother ... I am. I am terrible ... but** if they’re not pulling their weight and they’re not doing the right thing [tapping the table vigorously] well then, **I come down hard.**

Participants showed that the value of nurturing was an important value to have in the role of the CF. In this study, the CF’s role as the nurturer towards HSS as implied in the findings of Phase 1—Navigating current traffic conditions, under the theme of ‘Having green lights: Enabling the journey’.

In summary, the context of the CF’s toolbox has described the tools and values used to I, A & M risk to students’ progress and readiness. The tools were associated with familiarity and backgrounds. The most important value was transparency and being nurturing towards students and other nurses. Without these tools, the ability to I, A & M risk was hampered.

The next major theme describes and interprets how the CFs had responded to the current conditions they had experienced. Interpretations are made about the turning towards or away from values they considered were important.

4.5 Responses to Navigating Current Traffic Conditions

This section describes how participants responded to a range of feelings and thoughts related to being able to move past the obstacles they had experienced. Figure 73 illustrates where the participants ‘Response to navigating current traffic conditions’ sits in the STR framework.

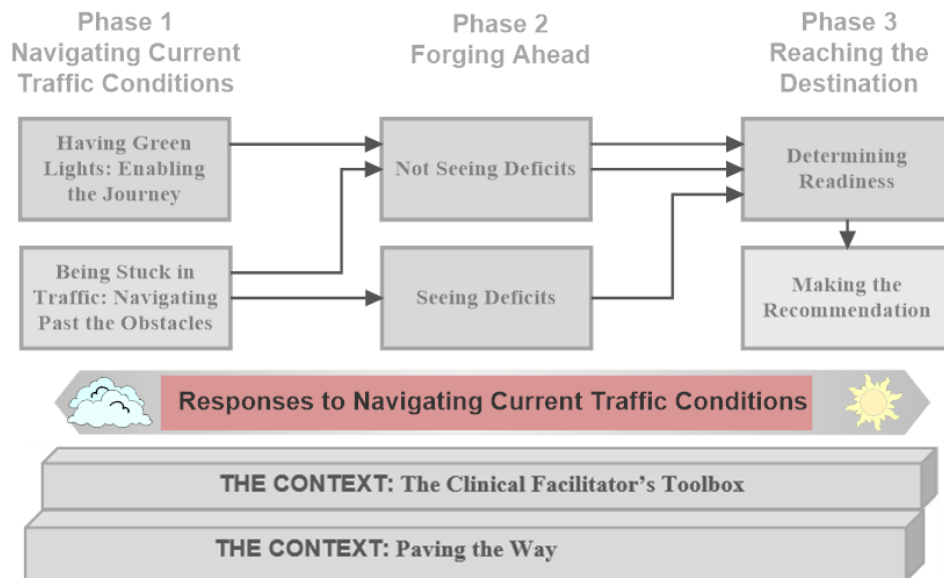


Figure 73: Responses to navigating current traffic conditions

In this theme of ‘Responses to navigating current traffic conditions’, participants responded to factors related to the context of backgrounds, the provider’s resources and the relationships they had with other nursing professionals. During the first round of interviews, four themes emerged and were then verified or disputed by participants in the second interview to ascertain how they felt about these themes: ‘Feeling alone’, questioning ‘Am I doing it right’, ‘Hands are tied’ and ‘Keeping quiet’. These feelings influenced how participants turned towards or away from behaviour that appeared best to support students in final placement. To use the driving analogy, repeatedly facing the same obstacles without some resolution can be likened to being on a roundabout, where ‘a cloud of doubt’ surrounds decision making and produces feelings of uncertainty & of being alone. Elly stated:

You keep all of this in your heart and you keep writing your notes, but it would be nice, to be nice to **share** the burden ... So, I think that needs to happen ... so, it’s

not **just your decisions** ... But when you start, I did feel very much alone. To talk to someone to talk someone about ‘Are they failing? Are they safe?’.

Figure 74 illustrates how individual responses can further increase the range of feelings CFs had lived with.

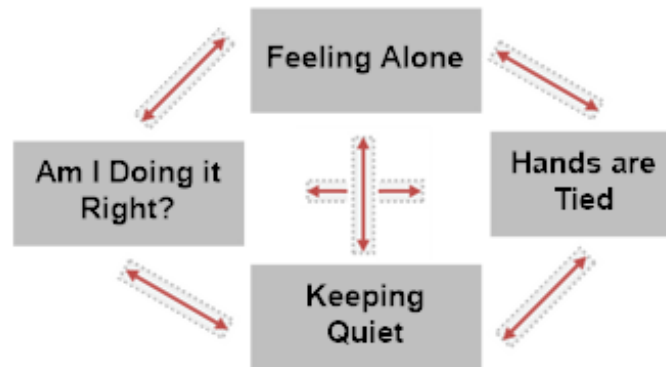


Figure 74: CF responses to the contexts and the conditions

The responses of ‘Feeling alone’, ‘Am I doing it right?’, ‘Hands are tied’ and ‘Keeping quiet’ are now described and interpreted.

4.5.1.1 *Feeling Alone*

This sub-theme of feeling alone describes how the participants responded to the sense of feeling alone or isolated in their role of CF. The sense of aloneness was related to the type of relationships they had with academics and individual members of the clinical teams (see Figure 75).

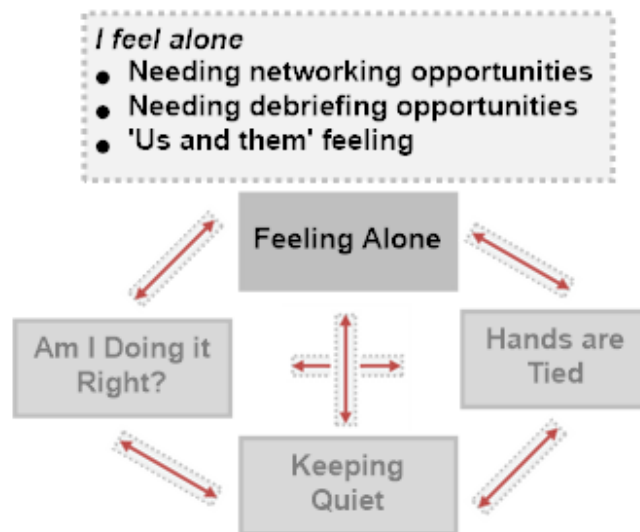


Figure 75: Feeling alone

Elly reported:

I think clinical facilitators **should** have more of an opportunity to have meetings. ... we could say, 'This is my student. This is what is going on. What do you think? How do you think **we** could help them, or what's **your** input?'. I think we **need** more of that. That would make our life easier. It would help because 6 weeks on your own is a long time ... I **do** feel that our job is very isolating. When you go into a strange place and it's very [pause] I sometimes feel it's **us and them** so ... they see me as '**oh my god**' ... I **hate** that feeling. Like, you feel like you're in the way sometimes ... You're sort of at a loss ... You do, you really look at **all** the pros and cons and sometimes you think '**Oh my god! This is my decision**' ... but some will protect students.

The reported need for debriefing sessions indicated that CFs would feel less alone when trying to move students past obstacles. In dealing with issues CFs needed the support of the HEP's clinical team or colleagues to discover the truth about student progression; the 'us and them' feeling limited Elly's ability to perform her role in managing the students' need for support. This hostility could explain why some CFs could 'turn away' from investing in relationships with HSS.

Gemma reported that she also felt alone: 'There are times when I get really lonely ... I know you can pick up the phone and call the next person at uni, but **like** I said, they're not always available'. The ease with which Gemma was able to access support appeared to be meaningful to her and the absence of having easy access meant that she felt alone in trying to manage student obstacles.

Barbara reported: 'Yeah there wasn't a process that if you wanted to as a facilitator, or as a group, that facilitators could utilise to discuss their concerns'. Not having processes to enhance the facilitation role influenced how facilitators managed student progression and removed this sense of isolation.

In summary, participants who did not have a process such as debriefing sessions and colleagues to chat with had felt alone. It was evident that some participants needed more supportive processes to share ways to identify and to assess the safety of student practice. Without this support, the CFs felt unsure about if they were doing it right.

This cloud of doubt was further extended when participants asked ‘Am I doing it right?’.

4.5.1.2 Am I Doing it Right?

Some participants described how they had previously had limited training in facilitation and how it was their facilitation experiences that had prepared them for managing students who had struggled. This theme shows how a cloud of doubt had or had not hung over participants questioning if they were facilitating students the right way in this journey. Figure 76 illustrates the concept of ‘Am I doing it right?’.

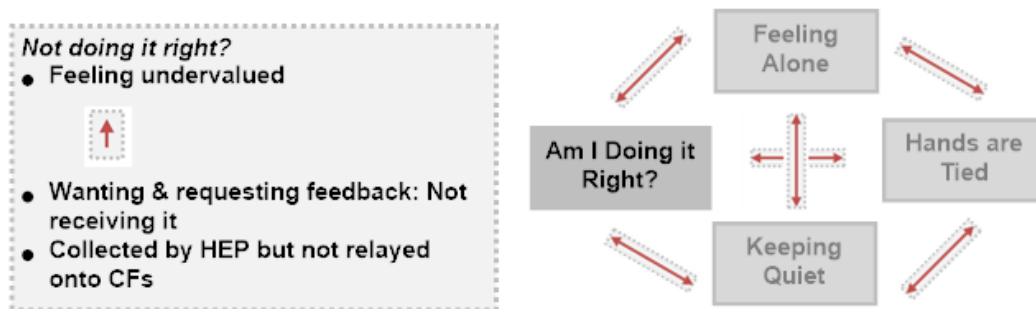


Figure 76: Am I doing it right?

Ashley described how HEPs did not appear to value the opportunity to evaluate CFs and provide them with feedback about the support they had provided to students. She reported:

Something that has bothered me is the lack of a) training and b) evaluation of clinical facilitators ... I have never been evaluated ... that worries me ... I have **raised** it with the person whom I report to. It has never been adopted and **therefore** if **we** are not being assessed as being organised or need help in certain areas of facilitating students, then **how do we improve?**

Ashley had a ‘cloud of doubt’ hanging over her as she did not know how to improve without such feedback. This state of being also highlights a state of uncertainty. In addition, Ashley felt, ‘Well, perhaps the term to use is undervalued’. Debbie also expressed her disappointment that although HEPs did collect student feedback regarding facilitator support, this feedback was not provided to her. She reported:

Yeah. We never got any feedback about anything. Even at the beginning, the students had to do an evaluation on the facilitator, but we were never, ever given feedback. I think we should be able to get some feedback about what the students thought about you as we might think that we have done a good job and the students think you haven't done a good job.

Caroline reflected on how her HEP had obtained student feedback about the support she had provided to students, but it had not been given to her. The collection of this feedback indicated that the HEPs were interested in how students were supported; however, the CFs' need for feedback appeared to have been overlooked by the HEP's clinical teams. The participants' feelings of being undervalued, of feeling alone where their hands were also tied were likely to undermine the voicing of issues and the sustainability of quality support.

Participant uncertainty was based on a lack of evaluation of key performance indicators from the HEP and a lack of feedback received from students. As key performance indicators were not identified, this gap in the data may warrant further exploration. In this context, the CF did not have a relationship that bridged for their needs, but instead appeared to have struggled with the expectations of both HEPs, HSPs and themselves. They required more input to bridge this gap between performance and knowledge.

4.5.1.3 Hands Are Tied

'Hands are tied' is the metaphor used to illustrate how difficult participants felt it was to work with resources and co-drivers in preparing students for professional practice. Figure 77 illustrates the concept.

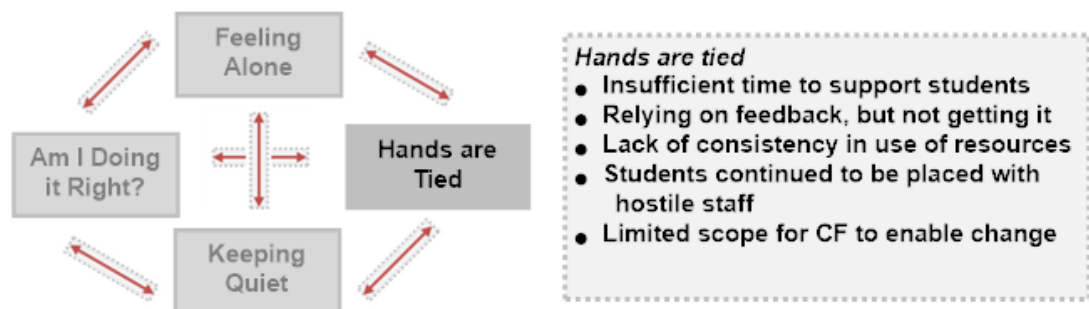


Figure 77: Hands are tied

In response to the theming of ‘Hands are tied’, some participants reported a sense of having their hands tied when obstacles were perceived to be outside their control. The obstacles were associated with having inadequate time to work with students, dealing with inaccurate feedback from HSS, dealing with mismatches in resources and relying on organisations to make student assessments about English language and comprehension to practice safely.

Participants responded negatively to the amount of time they had to manage student issues. Elly reported:

And then the facilitator [RN supervisor\ from the hospital is saying, ‘**No! This is how it is here**’. And then I feel that my hands are tied ... So, I find that is [pause] **hard**. It’s **hard for me** because I am not there to tell the staff how they should be doing it ... I think our hands are tied because we’ve only got ... 1 hour a week ... I don’t know how we can change that.

Ashley also reported:

The failure ... of your ward staff to come to me until late in the prac ... **I am only** in there for an hour a day ... that issue should have been identified earlier ... it really **made** me question, you know or well, maybe I’m losing it a little bit with this.

This appeared to be a situation in which participant struggled to feel in control of workplace practices and how the student was I, A & M when students were struggling. Participants appeared to be reliant upon the RN supervisors to alert them about student deficits and when this was not done, they could feel that their hands were tied.

Debbie indicated how her hands were tied when she was unable to manage other workplace factors such as workplace hostility towards students. Her student reported, ‘**I just can’t do it. I can’t** work with this nurse’. Debbie reconsidered past experiences she had with the student’s supervisors and realised the issue was not with the student. She reported:

I said I thought that last time I had a student here the problem was the student, but it’s not. It is obviously this nurse that is causing so much trouble with these students ... and she [the nurse manager] said, ‘Oh don’t worry; we know we’ve got problems with her. She won’t be given students again’ ... And then I bumped into [CF#2] the

other day ... this student; she said she had a terrible time over on the ward ... and she said the name and I said: 'She's not supposed to be having students anymore!' And this student nearly walked out and gave up her training because of this [tapping the table].

Without colleague input, Debbie would have been unaware of the ongoing effect the nurse was having on nursing students. Although she had taken action, there was a sense that her hands were tied and workplace pressures or weak leadership were unable to mitigate for hostile nursing supervisors. In this instance, she was unable to bridge for these situations.

In summary, the theme of 'Hands are tied' described how participants saw obstacles as challenges or as limiting their support to students. CFs felt powerless to I, A & M students effectively unless they were able to obtain support from other nurses. Participants appeared to need further support or debriefing about these issues.

4.5.1.4 Keeping Quiet

The theme of 'Keeping quiet' describes how the participants responded to navigating students within the context of dealing with hostility and poor professional practice. Figure 78 illustrates the concepts of keeping quiet.

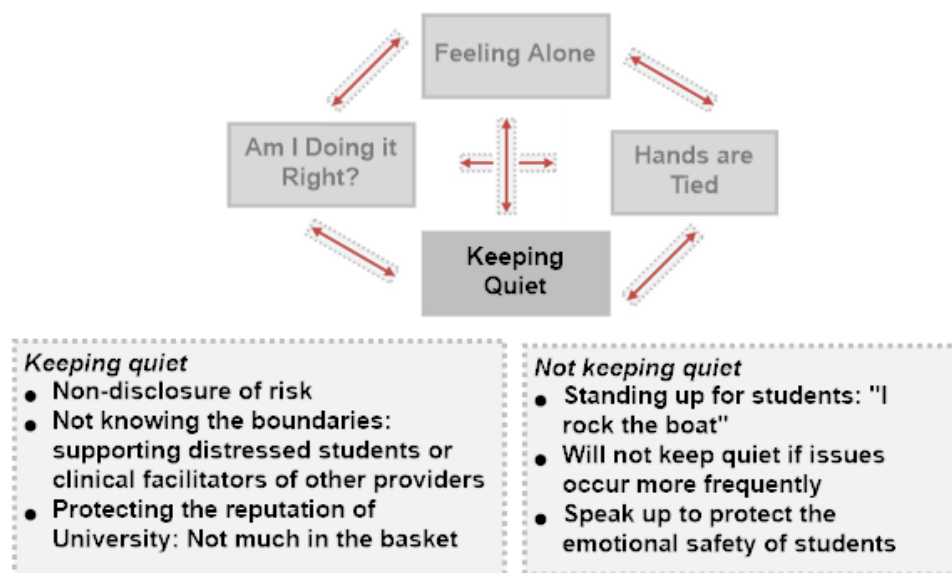


Figure 78: Keeping quiet

Participants reported that they would 'keep quiet' either at the HEP's request or to protect the university's opportunity for future student placements. Elly reported she

kept quiet about a struggling student by quietly introducing a learning and development plan (LDP). Elly was asked, ‘How did **not** disclosing the learning contract plan affect you?’, and she replied:

I feel like, **no, I, I, it's, it's terrible** because no one knows what my problems are. ... No one knows what the student's problems are. So, no one knows **what** information or **what support** they have to give the student. And then I feel **obligated** ... you know I am a nurse too. So, I want to protect the patients ... So, if I have a student that I know is unsafe and I can't tell the staff, ‘You need to watch this student **extra carefully**’, I go away thinking potentially what harm can they cause for patients in some situations as well. So, it's a stressor in **lots of ways** because I'm worrying about the student. I'm worried about the staff who **have no idea**.

This request meant that HSS were unaware of the potential for unsafe nursing care. In keeping quiet about a student's learning contract, Elly's anxiety had increased. In the context of the participants' toolbox, being transparent or open about the learning needs of students was highly valued. In this narrative, Elly was expected to turn away from these enabling factors of transparency, openness and collaboration. According to HTMETS (Figure 20) the turning away and ‘hiding one's genuine inclinations’ had produced distress and she was not able to look out for the safety of both patients and HSS. In this instance, she straddled a divide between the providers, statutory requirements for confidentiality and her own expectations for being open and for protecting nurses, students and patients.

Another participant described how she kept quiet about hostility towards an international student. Fiona reported:

I didn't say anything to anyone, and **do you know why?** Because in this instance you know, [HSP#18] and other places like [HSP#5] or [HSP#6] **if there is big disturbance**, it is **harder** for the uni to get placements because that facility can say ‘**No** we don't want anyone from [HEP#2] cause they're trouble makers’. So, you have to be really careful how you handle certain situations ... I spoke with a senior educator at [HEP#5] ... and she said you know, that when she is able to, she just takes the student out of that placement and places them somewhere else. Well, **we all know** that that's practically impossible ... that there is **not** much else in the basket. There's nothing available.

Fiona did not keep quiet but spoke out to an academic. However, managing prejudice was likely to be more difficult when bias was apparent in HSS. The CF was unlikely to be able to change the ward culture and it appeared as though the only thing she could do was to protect future student placements and alert the HEP who could take action to remove the student.

Although it was likely that most CFs would understand how health settings were hindered in providing placements, not all participants kept quiet about the issues concerning hostility towards students. Gemma managed for hostile relationships by initially keeping quiet. She reported:

And I thought because there has been **not one**, but three different complaints I probably will say something. But **how do you say something** in a subtle way; 'I'm not here to pick on your staff?'. Um, but I, at the same time I didn't want her making students feel like **that**. And whether she was aware of it or not, so **I had** to approach the staff development nurse and say I've had a few issues; it wasn't just one.

Participants were not silent as their focus was on the emotional safety of the students. Here Gemma used an approach of waiting so that she could assess how often hostility was shown by a member of the health setting's clinical team. This approach enabled her to notice the frequency of the hostility before opening a conversation and revealing how students were treated. Here she made connections about safety and student welfare and through being open with HSS bridged for a lack of knowledge by managers.

In Debbie's second interview, she agreed with the findings that placements appeared limited but had not let this deter her from reporting unprofessional behaviour of HSS. She reported:

I rock the boat. I rocked the boat at [HSP#6]. Um, the shit hit the fan out of there. You've got to stand up for the students if they're not been treated properly; if they're being bullied.

In summary, the responses of participants to the conditions in which they supervised students were either challenges that were not managed or were able to be managed. Taking the initiative to consult and use networks enabled participants to feel less isolated and that their hands were not tied; they did not remain quiet about the issues

they had experienced. However not all participants were able to manage feelings of being alone, feeling as though their hands were tied, questioning if they were doing it right, or wondering whether if they spoke up something would be done about the issues. Participants needed further support in the form of debriefing, feedback and networking.

4.6 Chapter Summary

This chapter identified the models used by providers and how equipped the participants were to take a final placement journey with students and HSS. ‘The context’ of the HEPs and HSPs were seen to pave the way for the journey. The quality of the supportive structures was significant in how participants perceived they could support students. Most concerning was the transient nature of supervision and relationships as well as the adoption of more task-orientated nursing to adjust for the skill mix and workplace demands.

The findings of ‘The context’ also describe how ‘the clinical facilitator’s toolbox’ was significant to identifying, assessing and managing of risks. Working in academia, knowing students and HSS and having clinical expertise were essential to deal with risks. The values related to the CFs’ expectations of themselves and of others were associated with transparency and of nurturing. Some participants reported they had felt alone, questioned if they were doing it right, felt their hands were tied or would remain silent about their concerns. The findings indicated that participants needed debriefing, feedback and networking opportunities to be more confident to deal with risk. Without this, a ‘cloud of doubt’ appeared to surround their management of risk.

The following chapters describe the three phases of the participants’ experiences: Phase 1—Navigating current traffic conditions, Phase 2—Forging ahead and Phase 3—Reaching the destination.

Chapter 5: Phase 1—Navigating Current Traffic Conditions

5.1 Introduction

In the previous chapter, the first major theme described the background and context of the providers and participants and the CF toolboxes. It also described the second major theme of participants, ‘Responses to navigating current traffic conditions’. This chapter describes the first phase of identifying, assessing and managing nursing students on a final placement: ‘Navigating current traffic conditions’. The first section defines how the identification, assessment and management of risk occurred, using the following operational definitions:

- identify: noticing, finding out or linking the risk with individuals likely to be at risk.
- assess: determining the scope of risk, and making a decision as to what can be done to reduce the risk.
- manage: developing a plan of action to mitigate the risk and monitoring the outcome.

Figure 79 illustrates the cycling process used to I, A & M risks.

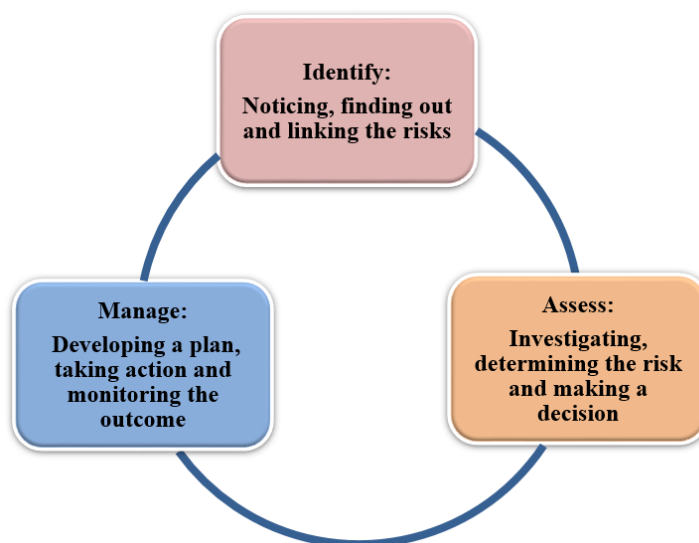


Figure 79: The cycle used to identify, assess and manage risks

This cycle of how risk was identified, assessed and managed is not just a ‘once only’ occurrence but an ongoing process throughout the practicum, where the elements in this cycle did not always occur in a linear progression. For example, if a CF found there was a risk to a student’s practice, they would investigate further to evaluate the risk and decide how best to reduce the risk. The CF would manage the situation by implementing a plan of action and regular monitoring. As the situation progressed, other factors may be found or linked to the risk, necessitating modifications to the plan of action. This was a process that could commence at any point in the cycle and move between any of the three parts to I, A & M risk. An example that described this process is provided by one of Barbara’s narratives:

I had a final-semester student who did a blood pressure ... and the new clinical deterioration chart had come out ... but she hadn't reported it to the registered nurse ... but there was a couple in the group that did not know **what** the actual chart was. So, I went through a session and explained that to them.

As experience and values are integral to a way of facilitating students, I used HTMETS (Figure 20) to explore paradigm shifts. These paradigm shifts explain how participants might turn towards or away from previous ways of managing students and provide insight into how these factors and the participants’ values have influenced them. In the above example, Barbara demonstrated authentic behaviour as she valued being able to assess students fairly. When paradigm shifts occurred, HTMETS (Figure 20) demonstrate how the paradigm shift was interpreted. In the above example Barbara did not turn away or towards authenticity but continued to be authentic in her approach as her actions matched her valuing of fairness.

The two themes covered in Phase 1—Navigating current traffic conditions are ‘Having greenlights: Enabling the journey’ and ‘Being stuck in traffic: Navigating past the obstacles’. Figure 80 illustrates where the first of these occurs in the STR framework.

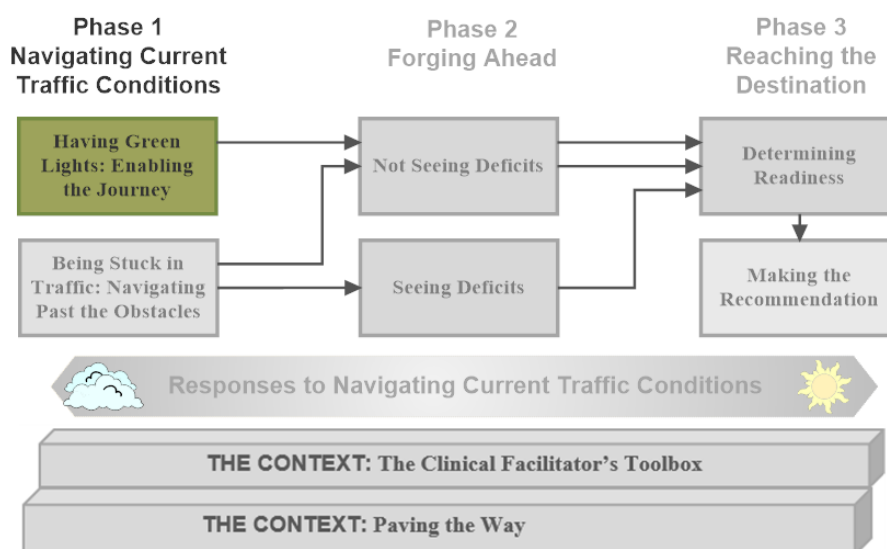


Figure 80: Phase 1—Navigating current traffic conditions: Having greenlights

‘Having greenlights: Enabling the journey’ is the theme that describes factors related to the participants’ emotional intelligence and social responsibility, the collaboration of workplaces and how the participant managed with the tools in their toolbox. The sub-themes for Phase 1—Navigating traffic conditions are identified in Table 4.

Table 4: Phase 1—Navigating current traffic conditions

Themes	Sub-themes
<i>Having greenlights: Enabling the journey</i>	Life experiences: A step ahead Identifying collaborative workplaces Managing with the toolbox
<i>Being stuck in traffic: Navigating past the obstacles</i>	Responding to obstacles related to people Responding to obstacles related to resources

5.2 Having Greenlights: Enabling the Journey

The theme ‘Having greenlights: Enabling the journey’ describes the participants’ lived experience of student and workplace attributes. These attributes were perceived to help students in a final placement to become ready for professional practice. Barbara stated:

What does influence the student's placement is if you have a nurse who is **really keen** on educating; who really **believes** in giving the students all the opportunities, who really takes them under their wing, and says ‘Okay’, and who is **also really**

proactive in making sure that the students learn. A nurse who **actually sees** it as **her** responsibility to facilitate education for the student.

The three sub-themes were ‘Life experiences: A step ahead’, ‘Identifying collaborative workplaces’ and ‘Managing with the toolbox’ (see Figure 81).

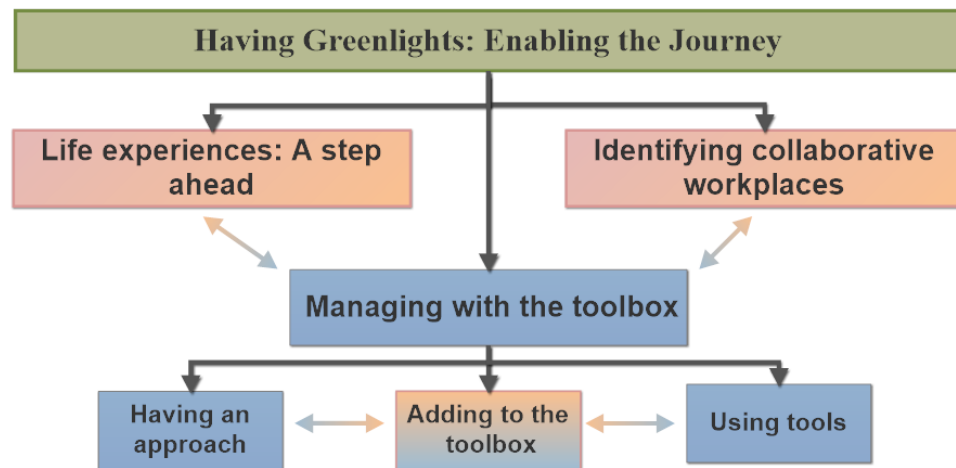


Figure 81: Having greenlights: Enabling the journey

5.2.1 Life Experiences: A Step Ahead

Participants identified that students who had life experience were considered ‘mature’ and this experience aided them in coping with and adjusting to the workplace. It indicated to them that the student was more likely to deal with issues of risk; participants identified that this experience lowered a student’s risk of not being ready at the end of final placement. Ashley reported:

It’s like **mature** students, who have **life experience**. How much **better** they cope with training. Okay, they’ve got to deal with kids at home, husbands and maybe part-time jobs, but **their life experience just** has them one or two steps ahead of others.

This indicated emotional maturity and provided a greater sense of social responsibility. Ashley also reported on the benefits of having work experience in a health setting:

The difference between a student who works in a care facility and who has both skills, time management skills, dealing with the elderly whatever, families, relatives prioritising care, comes into the RN program with **those basics already** in place, some better than others, but they have had exposure to it.

Students who had a background history of working in a health setting were recognised here as being advantaged. This experience was likely to lower the student's risk of not managing nursing care in the final placement. However, the experiences varied among students who had worked. Some students in a final placement had worked outside Australia in other health settings. Fiona had a student who had experience as a RN in another country. She reported;

But I have an overseas Saudi student (yes) at a hospital in Perth ... **already** he had a history in his country in working in a bone marrow transplant unit ... **already** an adult who had a long history of working in a hospital and he knew **exactly** what he was doing.

Fiona linked the student's working background in a health setting to his current proficiency. This background would suggest that this student had a considerable advantage compared with a student who did not have this experience. Although this student's experience was from overseas, the participant did not state how she assessed whether the student's prior experiences had matched the nursing care expected for Australian health professionals.

In summary, these narratives showed that experience and the ability to cope and learn was an advantage for lowering the risk to the student on final placement. These examples indicated that emotional intelligence and social responsibility were aspects of coping on a final placement and would assist students in workplaces to cope with the work relationships and demands of nursing.

5.2.2 Identifying Collaborative Workplaces

This theme describes how participants identified that collaborative workplaces consisted of staff providing learning opportunities and empathising with students who were on final placement. A collaborative workplace was believed to be one where each member of the team was valued and given opportunities for learning. Barbara noticed that the inclusion of students was significant for HSS to I, A & M risks. She reported:

If the unit manager, the staff development nurse, the clinical nurse, if they all collaborate and work together as a **team**, it is obvious on the ward, as teamwork is part of it. **You can't help but see it** ... they incorporate a student in that team ... **If** there is any hiccups going on ... it's usually addressed there and then.

It appeared that senior staff set the tone for the clinical areas and managed issues as they arose. This narrative implied a sense of collegiality and collaboration; where the staff and the participant had common goals of supporting students. The risks were lessened for the student as they were included in the clinical team and were led and guided by them.

A collaborative workplace was also believed to be one opportunity for learning to be extended when HSS took the time to explore and review the student's learning objectives. These objectives focussed on specific nursing care tasks and the supervising nurse could provide feedback about the provision of care. Elly reported:

Good feedback, if I was a staff member and working with the student on the floor, I would always **want** them to set their objectives at the start of the day and then have a little debrief before they go home. Discuss how the day went. What they did well. What they could do better next and not go home and worry about, '**Oh my god, that was a terrible day**', but instead, 'Okay, that's okay, that's today. **Tomorrow** we're gonna try and get the same patients and let's see what we can do differently'.

HSS who led and guided students were in effect 'turning the traffic lights green' so that students could journey onwards.

Debbie verbalised how she noticed a new graduate nurse who ensured her student had the opportunity to provide total nursing care for patients:

She has only recently finished her training in England, but she's come out here ... she knows they're third years. She just right from the word go said, '**Right, these are your patients. Go for it!**' ... 'I'll be here if you want me'. Yeah, but she lets them go.

In summary, HSS in a collaborative environment steered or guided the student onwards to demonstrate behaviour that exemplified the role of the RN. 'Having greenlights: Enabling the journey' describes how the collaborative team of HSS valued and included students as 'part' of the clinical team. Consequently, opportunities to provide patient care were given to students and helped them become ready for the role of the RN; issues were promptly managed.

5.2.3 Managing With the Toolbox

The sub-theme ‘Managing with the toolbox’ shows that tools were essential to assist participants to carry out their facilitation role. Part of managing with the toolbox was how the participants approached their role in identifying and assessing risk and in managing this risk. The other parts of managing their toolboxes included how they added tools to their toolbox and how they used the NCAS (Brown, 2016) to obtain evidence about a student’s readiness for professional practice. The three sub-themes as shown in Figure 82 are ‘Having an approach’, ‘Adding to the toolbox’ and ‘Using tools’.

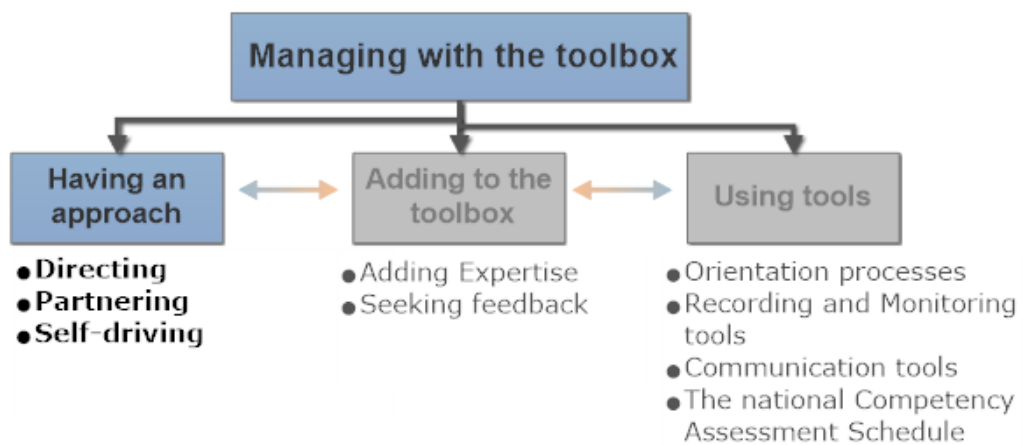


Figure 82: Sub-themes of ‘Managing with the toolbox’

5.2.3.1 Having an Approach

The CFs appeared to approach the process of clinical facilitation in a variety of ways. Participants explained how they had used a specific approach or a mix of approaches to facilitate students. These approaches, as illustrated in Figure 83, were ‘directing’, ‘partnering’ with or expecting ‘self-driving’ in student learning. The bidirectional arrows illustrate that the approaches to manage students were adjusted to the situation in which participants found themselves. These three approaches are now described.

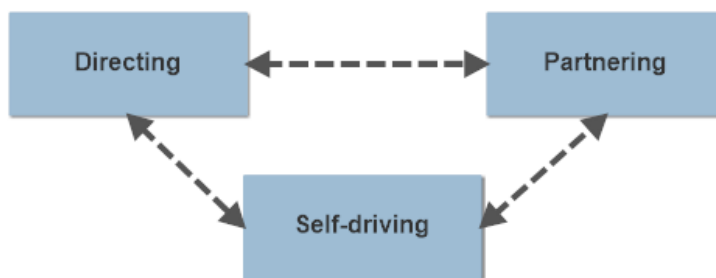


Figure 83: Facilitation approaches

5.2.3.1.1 Directing

Participants described how they would take control, direct students and expect them to defer to them. Fiona reported, ‘I am your manager **now**. The uni is there, but you **go through me** to get everything organised, so they don't be confused’. Fiona perceived that students needed direction and took control of what was happening with them. Caroline reported, ‘I can really teach those kids’. Directing students appeared to be the role of not only the manager or the teacher, but of the director and the modeller of professional behaviour.

Elly also reported on how she took control and directed students verbally:

We have to **drive and direct them** so that they know what's expected. Cause a lot of them come in, and they don't know well, where, **what should I look like** at the end. So, we can make them see what they should be doing and help them **get** there by simple things; by setting short-term goals on a daily basis.

Elly used the direct approach to control and direct behaviour and the planning of nursing care. Likewise, Barbara directed students by modelling professional behaviour. She reported:

It's often what we do, not what we say. So, I am very mindful of this when I am with the students, so that when I call them on you know, time, signature, documentation, I have to be mindful about mine as well.

When students could see the behaviour modelled, they were more likely to be ready for practice. However, Barbara showed she was using a mixed approach as this narrative also indicated that she held students accountable for taking control of their behaviour. The directive approach in clinical facilitation was likely to benefit students

who needed direction. She also made the connection with working alongside students by modelling the behaviour so that she could direct students to change their behaviour.

5.2.3.1.2 Partnering

This approach appeared to be one where the CF worked alongside students to guide them or assist them in solving problems. Barbara explained how she had adopted her facilitation approach more towards that of working alongside students:

I know in my younger years I had this approach that I am the facilitator, and you're the student. I **don't** have that anymore ... I've got an experience, and I am here to facilitate **yours**. I like to get to know who they are ... I **never** saw myself as above them. I **worked** alongside them So, it is a very transparent conversation, and I actually set up how, or what they need to do to pass, also what will happen, or, what a fail looks like for them as well, and that it is really an experience that they can choose to pass or fail.

Here Barbara's overall shift was influenced by experiences and the development of expertise. HTMETs can be used to describe this shift in behaviour. Barbara's reflections on these differences would be described as 'an unfolding event, in the process of realisation' (Figure 20, HTMETs #6). Here she outlined the risks and directed them on the expectations. She then expected the students to take control of their learning.

Ashley considered she was the 'go-to person' and would be there to support students who might be struggling. She reported:

The role at the moment is the go-to person for that student. We will look at what they are doing clinically on the floor and **every day** I will come away with the student. '**Sit** down! Now **tell** me what's going on'. So, the student **feels** safe to do that. That forms our relationship, and I can feed back in terms of ... about strategies. How to manage this kind of situation and **you're** separated from that ward culture and protecting the student.

This approach showed cooperation as she wanted students to open up about issues so that she could guide them. Once students had been given guidance or helped to solve the issues they had experienced, students could take control and drive their learning. As a result of this experience, Barbara and Ashley operated with a shared approach.

They were able to consider points of view that helped them to make sense of the surrounding world. HTMETs would describe this existence as being ‘attuned to a quest for shared community values’ (Figure 20, HTMETs #13). The next approach to facilitation was expecting students to initiate and drive learning as required.

5.2.3.1.3 Self-driving

The CF using this approach expected that students would manage their learning needs and plan their way during the learning period. Fiona expected her students to be responsible for their learning. She reported, ‘In third year I am expecting them to **be self-driven**; to have their time planner ready’. Likewise, Barbara indicated that it was the students who drove their learning and who were responsible for their professional practice. She reported:

And the students, you know ... I do have an expectation that students will **drive** their learning. I'm not there to tell them what to do, when to do it and how to do it. It's up to them to actually drive it and take ownership of it. Like they would if it was their workload. So, I say to them, I am available; you **tell me** when you want me to come and do things with you.

For students to demonstrate professional behaviours, they needed to be accountable for their professional practice and be proactive in their learning.

In summary, the approaches used were ones of directing, of working alongside students and of expecting students to drive their learning. When the participant needed to take control, a direct approach was used. Partnering with students appeared to be a sharing of the control and of the identification and assessment of risk. In some instances, the CF expected students to independently drive their learning. In some narratives, the experience of facilitation over time had altered an participant’s approach and participants appeared to use more than one approach to facilitation.

The next element describes how participants added to their toolbox. Adding to the toolbox equipped them with how to identify and assess risk. It also assisted them with ways to manage and monitor risks, particularly for students who were struggling.

5.2.3.2 Adding to the Toolbox

‘Adding to the toolbox’ is a sub-theme that describes how participants utilised a background of experience, knowledge and expertise and had utilised other resources and tools to guide them. The model of the toolbox arose during the interpretation of data and appeared an essential piece of equipment for the journey. All participants came to the role with various tools they could utilise to I, A & M risk. The two parts of the sub-element are illustrated in Figure 84 and are ‘Adding expertise’ and ‘Seeking feedback’.

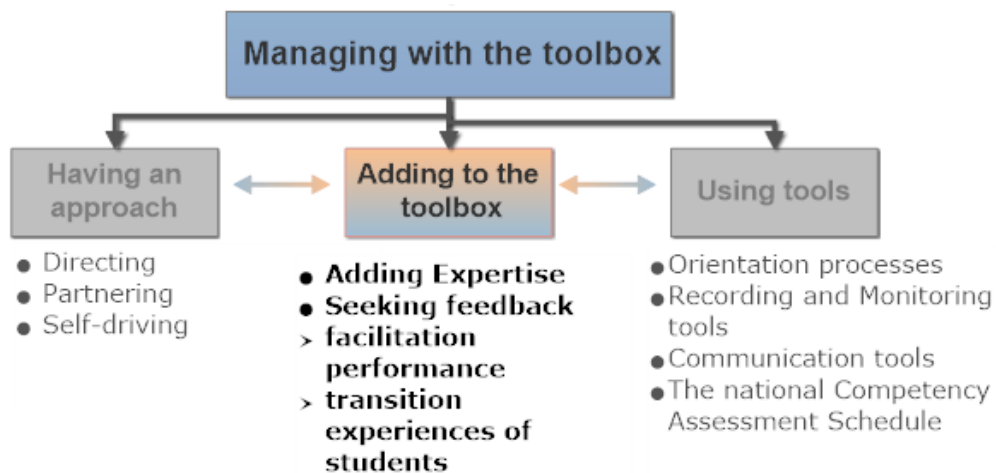


Figure 84: Adding to the toolbox

5.2.3.2.1 Adding Expertise

Adding expertise is a sub-element that describes how participants added to their toolbox from their experiences in facilitation and from the experiences of others. Debbie had planned to add to her expertise by going to an education session. She reported:

We’re going to a training thing on Thursday. ‘Promoting quality clinical supervision: The supervisory relationship’ ... and we are doing an intermediate workshop because you know, we are experienced and we have been doing it for a while.

This narrative described how education was in place for supervisors. The term ‘supervisor’ was a term to describe both CFs and CSs of nursing students.

Other participants had added experience and had developed their expertise. Barbara reported:

I've worked it out; I thought that my only experience was as a registered nurse, 'What do I need to know'. So, my experience as a graduate, my own experience as a nurse that goes and works in different wards.

Similarly, Elly reported on how over time the facilitation experience had honed her expertise. Initially, she questioned what she should be doing and reported:

Well, I feel that I'm **better now than when I started** and only through experience. You know what, what's expected. You know how to help. You know how to ask the **right questions**. You can, you can work out if a student's struggling or you know that they're okay just by the questions you ask. So, when I started, you didn't know. You go '**What actually should I be doing?** What questions should I be asking? How do I know that they're okay?'

This element has described how almost half of the participants added to their toolbox through experiential practice. The next element describes how participants facilitated students with the aid of tools. These tools were used to monitor and evaluate the students' progress towards professional practice. The tools used were both recording and monitoring tools provided by individual facilitators and the HEPs.

5.2.3.2.2 Seeking Feedback

Participants reflected on their facilitation experiences and how to improve support. They also reported on feedback they received about student experiences. Feedback was associated with their role as a facilitator or about the transition of students to the role of the RN. This feedback influenced how they reflected on their practice. The sub-elements are 'Facilitation performance' and the 'Transition experiences of students'.

5.2.3.2.2.1 Facilitation Performance

During the students' final placement, a small number of participants obtained feedback from students to improve the quality of the support they had provided. Barbara reported, 'It was also important for me to get it from the students ...When I **first** started, I evaluated my practice every prac'. When asked why she did this, Barbara explained, 'Why did I do that? [pause] Because **I didn't know if I was doing it right.**

I didn't have any other form of feedback'. She identified the need to know how she was going:

Sure, the students will give you feedback. They will only tell you what you want to hear. Whereas, if I made it **anonymous**, and that there was no **comeback**, and that, they could be as honest, and that the feedback wasn't compulsory. It was an opportunity for me to get constructive feedback. Cause I **didn't** have it from anywhere else.

To assess the feedback, Barbara had a system that would ensure students could be honest and open about her support. She reported, 'So I would see that there was a **theme** like I have an 80/20% say it is like that, then it is. So, **what am I going to do about it?**'. From this assessment, she was able to identify what she needed to change to help students who practised in a final placement and then manage the changes to her facilitation process.

Harry wanted to know if what he had taught in university was useful to his students in becoming work ready. He reported:

You get feedback from how they're doing ... Everything that you learnt over the time you were at uni, did you find it relevant? And she said 'the drugs and alcohol stuff **no**, this we didn't, this we didn't, **but the stuff that you taught me** on communications' blah, blah, blah, **fantastic**.

Seeking feedback from students about the participants' facilitation performance appeared a valuable asset to improving how they acted in the future. The next sub-element describes how participants added to their toolbox by seeking feedback from the transitioning experiences of students on employment.

5.2.3.2.2.2 Transition Experiences of Students

Some participants actively sought feedback from students who had transitioned to the role of the RN and were employed by a HSP. Participants still referred to them as students as they had been their student while on a final placement. Barbara verbalised the questions she had asked of past students: 'What has been the **biggest** learning curve? What have you found the **easiest** and what have you found the **hardest** to do?'. She reported:

Time management. They will always say to me ... No one tells me, like, you know, 'I've got 14 sets of meds to give out and I just **don't** have enough time because I **don't do** that when I am a final, you know, semester. I don't **give** out 14 sets of meds' ... But also, the ownership and the responsibility that **they're actually the voice of the patient and they need to speak up** ... What they've found the most difficult, is their time management and actually communicating to the other staff about their patients and **actually taking sole responsibility for the patient.**

When assessing this feedback, Barbara could make a decision that students needed practice with medications. They also needed to be responsible, manage their time and communicate the needs of patients. Having this information informed Barbara of where she needed to direct her energy to support students.

Elly described how she felt having spoken to her students:

Because it **does affect me** seeing the students out in [HSP#4] when they're saying to me, and I was hugging a student that came out **crying** because she felt she just wasn't ready and that affects me. So I think, 'how do I do my job to **stop** the next lot of students being in this situation?'.

In summary, the participants were able to refine their process of facilitation when they had received feedback from students about the effectiveness of a final placement prior to nursing registration. This feedback gave them insight into areas that had or had not met the learning needs of students. The next element describes how participants used recording and monitoring tools to meet the requirements for nurse training and competency.

5.2.3.3 Using Tools

This next element of the sub-theme 'Managing with the toolbox' describes how participants used tools to manage risks to student failure. These tools consisted of orientation, recording and monitoring tools, communication tools and the NCAS (see Figure 85).

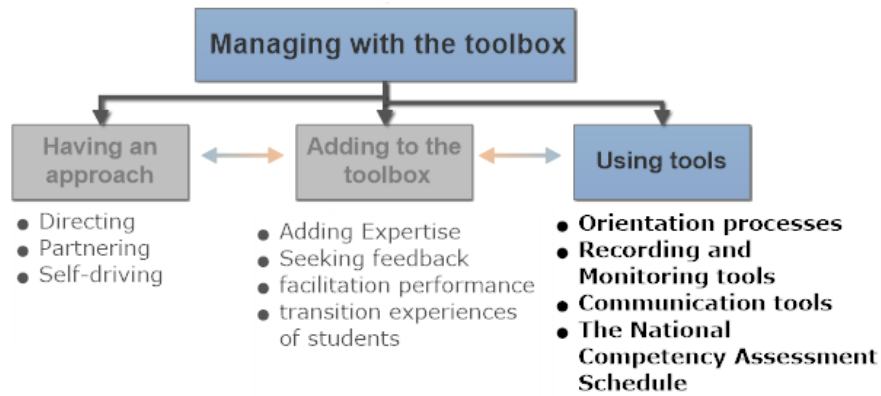


Figure 85: Using tools

5.2.3.3.1 Orientation Processes

Participants described the need to orientate students to the health setting environment, staff, specialty areas and their expectations for the student’s placement. Usually, the orientation period was a settling-in period as participants described a variety of orientation approaches with students. The breadth of orientation practices began from before the placement and continued throughout the placement.

Caroline commenced orientation before the students’ commencement of their placement. She sent her students a letter stating what she had expected from them on the day of orientation. Caroline reported:

I have already sent them [students] a letter ... The managers put it [a seminar room] aside for me for the day so I go up there and organise; they have to do this e-learning package. I’ve always organised with the library to have so many computers ... but I organise this 3 to 6 weeks before.

Further to this, her process of orientating students was a stepped-out and highly organised process where she accessed the skills and knowledge related to the specialty area. She reported:

I just go through it, what the anaesthetist does ... the anaesthetic technician and the surgeon, what his role is ... Then what I do is I take them into a theatre ... and then I get them to practice their gown and glove ... and also get the instruments ... But you will have one student who will have to experience holding bay and recovery for 1 day ... Another person will be in anaesthetics ... And each, each student does that.

This approach suggested she employed a staged approach to providing opportunities to orientate students to skills, and that practice during the theatre placement would minimise the risk of not understanding what was required. She ‘drove’ learning by using ‘theatre-specific’ learning objectives. There was a sense that Caroline was in control of the students’ orientation to their theatre experience. It is unlikely that a facilitator unfamiliar with the theatre environment would be able to provide this level of orientation and support to students in this type of setting.

Barbara provided orientation for her students by using a personal orientation list with clear expectations for the students during the placement. She reported:

I've got my own. [sounds sheepish] [pause] ... So, I started an orientation list ... First day is orientation day. Second day, they do a time management grid and they have their handover notes ... and let them fit in ... I introduce myself and I introduce the students ... It's about setting an example of how they can approach the ward. They can say ‘Hi my name’s ... I have never worked here before ... I am here for 3 months’.

This settling-in period suggested that students must first become orientated to their surroundings and Barbara guided them in how to socialise and make supervising nurses aware of their previous opportunities to practice:

If it’s a new environment, they have to discover where their resources are, so ‘**Where’s** the hospital policies? Who are they going to ask if I wasn’t there? How do they know their own scope?’ ... making sure they know what they **can** and **can’t** do to be safe. Know where their resources are, who their resource people are and just you know, learning the routine. So that’s just the first 2 weeks.

To provide further support to students, participants used other strategies to deal with communicating with them. Some participants actively opened up support to students by providing them with their telephone number. Ashley verbalised, ‘I say to my students you can ring me anytime. **They have to have** someone that they can call on’. In this situation, Ashley supported her student in a community setting. The staff were responsible for managing this student’s progress and Ashley maintained phone contact to support her. This phone support suggested that students might need to access CFs during or outside the shift time to discuss their concerns or needs with the CFs.

In summary, the strategies participants used to support students in a final placement were varied and indicated that adequate orientation would minimise risk. These variants included contacting students prior to their commencement in the health setting; introducing them to specific skills used in clinical specialties area and ward routines; facilitating student online learning requirements; and identifying where resources were located. They also outlined what they had expected them students, the use of their scope of practice, and the need to be self-driven and to take up opportunities to learn.

5.2.3.3.2 Recording and Monitoring Tools

The assessment of students' progress was measured against the expectations and learning objectives for the final placement. Participants appeared to keep an accurate record about this progression. The recorded evidence was the act of recording perceived risks and showing how the assessment of risk was identified, assessed and managed.

Ashley reported, 'I **ask** them to document the skills they have done'. Ida reported, 'I kept records and databases'. Barbara reported, 'I write notes **constantly** ... I have a **diary. Everything gets documented** and I ask a lot of questions'.

Some participants reported that they would check the students' 'time sheets'. Ida reported, '[I] had my little rosters, so I knew which students were on an **early and late**'. Debbie reported, 'when you're filling out their paperwork as well, you've got to be aware of "Okay I've signed it off as well ... yeah, he's done 40 hours this week"'. If students missed this time, they needed to make up the hours. Fiona reported on monitoring a student who had family issues with which he was dealing and who needed to make up the time he had been absent from the clinical area. She stated, 'He had very sick children at home and always asked for permission if he could go home to attend to his family and then he **did** make up a lot of hours'.

In summary, the recording and monitoring tools kept CFs informed about the progress of the students who were on final placements. The diary of clinical hours the student had worked assisted CFs with knowing when students were at risk of not completing the required hours by ensuring they were able to visit the placement location during the times the student was working. The diary was a record that could account for the

management of risk. The next element describes how communication tools were used to manage risks.

5.2.3.3.3 Communication Tools

Some participants reported on tools they used to assess a student's ability to communicate. A communication tool used by participants to I, A & M risk was the tool taught and used for handing over of patient care. To use this model (ISOBAR) students were expected to identify whom they were reporting, what the situation was, what they had observed, the patient's background and the agreed plan, and to read back where they could clarify any questions from the clinical team that were going to take over the patient's care (ACSQH, 2010). This approach was taught by HEPs and when students arrived in the health setting, they used the health settings checklist for handing over patient care; the CF could then assess whether a student was handing over as per the health setting directive.

Barbara identified that she used a template to show students how to communicate and 'handover' their patient care. Here she actively managed students in a way that allowed her to identify and assess the safe use of the tool. She provided her students with immediate access to the tool. Barbara reported:

How to give handover with ISOBAR. So, I've actually got a sheet that it's got, not just ISOBAR on it ... so if you were reading patients' handover notes, what goes under I, what goes under S what goes under O. So that's a tool they all get.

A further tool to clarify communication skills was a HEP communication rubric that was used to assess specific communication skills of international students who used ESL. This tool was a clinical rubric designed to be used for a formal evaluation midway and at the completion of the student's placement. The tool was used to evaluate the student's ability to sufficiently read, write, listen and comprehend what was being said or written. Elly reported, 'So, with the uni that I work at we do have the rubric for communication. So, it covers areas of speech, listening, reading etcetera, etcetera, that is done at the halfway mark and at the end'.

Elly was asked by the interviewer: 'So what did you do before you had that tool to assess students' communication?'. She responded:

To be honest, I think **that it wasn't managed very well**. I think we didn't really, I think we would be looking at their **verbal communication**, but I think students could fall through the cracks if they didn't actually be honest and say what they could and couldn't read ... I tend to do it more than just at the halfway mark and at the final mark so that I can **identify things earlier**.

This indicated that she was doing both formal and informal assessments and suggested that this tool provided her with the means to take control of identifying, assessing and managing the risks associated with poor communication. Although Elly could confidently use the communication rubric, she did not feel HSS would be able to use it effectively. She reported, 'I tend to do that **myself** rather than **leaving that up to a preceptor** only because I feel that I have more of an experience to judge what level they should be at'.

When needed, Gemma understood that the HEP would provide additional support for students who struggled with the English language. She reported, 'And another thing that I think that a lot of unis provide is extra English classes or tuition before, as I have that experience before they say "Yep we will set them up for extra English classes"'. Gemma was confident that risk to communication was managed.

In summary, these tools were not sourced by the participants but were among the resources provided by the HEP and the HSP and had assisted participants to I, A & M risks that would hinder progression. The next element describes a further tool provided by HEPs: the NCAS, which each individual HEP modified for their students in a final placement. This formal tool was used to record written evidence of students' practical development of skills and professional behaviour. Written evidence of demonstration validated why students should be recommended for nursing registration.

5.2.3.3.4 *The Nursing Competency Assessment Schedule*

HSS and CFs evaluated and identified readiness to practice from students' reflections, the observation of their practice and reaching the competency levels for a final placement as set out by the HEP documents, which were based on the NCAS. Before the NCAS, students were assessed using clinical evaluation forms developed by individual HEPs. Similar to the NCAS, students provided written evidence of how they had made links between the RN Standards and their clinical practice.

Ashley reported that in her students' NCAS documents they were expected to undertake an assessment of three to four specific skills. Her students had to also complete a reflection on those skills. She reported:

Because its skills based again, so each student comes out and depending on their stage may have three or four skills to achieve in the 3 weeks and writes a reflection on those skills and writes an overall reflection for the prac. In the **old format**, in writing entries every day against the different domains and the **different standards** within the domains, **at least identified** whether the student understood the **domain and the standard as part of the domain** ... Look, if I don't drill down with the student in **the new format**, I have no way of knowing that she understands the standard or understands how the standard applies within that domain to the patient she's cared for. So, **it does** require, a more **in-depth interview** from me on a daily basis.

The old format of the NCAS was one that allowed Ashley more easily to evaluate how the student understood clinical practice according to standards. Elly similarly reported on this difficulty with the introduction of the new NCAS: 'The NCAS [nodding] Yeah. All of those things are hidden in the NCAS, but they're not really assessed'.

Fiona reported that students were often confused about how to articulate competent practice:

I think they find that the most **confusing** bit, uh, you know matching their tasks to the domains and I say to them it is a case of mix and match. **What you do** will be written up as a domain and vice versa.

Barbara also assessed and identified issues by reading the students' reflections, reporting that, 'Yeah, I will **assess** the student for their **competencies**. I will ask them to, I **read** their **reflections**. I **ask** them to document the skills they have done'. These narratives described a process of checking or monitoring a student's ability to articulate and identify how they were meeting the national standards for competency.

This discussion of the use of various approaches to supervising students, adding to the toolbox and using tools has described how the participants had approaches and tools that they utilised to support students in a final placement. Participants wanted to take control of orientating students to the expectations for a final placement. They had

reflected on how others and they had experienced this journey and had used tools to monitor and record the progress of students. They utilised communication tools to I, A & M risk with student progress. Knowing the limitations of an HEP's NCAS ensured that participants could take control of the assessment by giving more time to consolidate and assess students' understanding of the RN Standards.

In summary, the first theme, 'Having greenlights: Enabling the journey', has been described. Previous experience of being employed by health settings was likened to driving onwards with all lights being green, where the traffic conditions favoured rapid progression and could increase the student's ability to cope with the stressors of the workplace. The participants also used a variety of approaches to facilitate student learning and to manage risk. To manage the risk associated with struggling students, it seemed participants needed to take a more directive approach. A significant finding was how participants valued adding skills and tools to their toolboxes.

This theme is now concluded. The next theme of Phase 1—Being stuck in traffic and navigating for obstacles describes the factors that participants had identified, assessed and managed while students were on a final placement. This theme is titled 'Being stuck in traffic; navigating past the obstacles'.

5.3 Being Stuck in Traffic: Navigating Past the Obstacles

The second theme of Phase 1 is 'Being stuck in traffic: Navigating past the obstacles', which describes the factors that hindered students in becoming ready and how participants had responded to these factors. These factors were related to providers and 'co-drivers' such as facilitators, HSS and students. Participants had responded to factors related to people and resources. Of significance, participants described the effect on relationships. Elly stated:

Particularly later on, with final-semester students because I am only there with them for 1 hour per week, so I **really have to have** a good relationship with the hospital staff. Which **takes a while** to build that rapport, otherwise you're just an outsider, and they just look at you like 'you are just holding up my day'.

Figure 86 illustrates the theme of 'Being stuck in traffic: Navigating past the obstacles'.

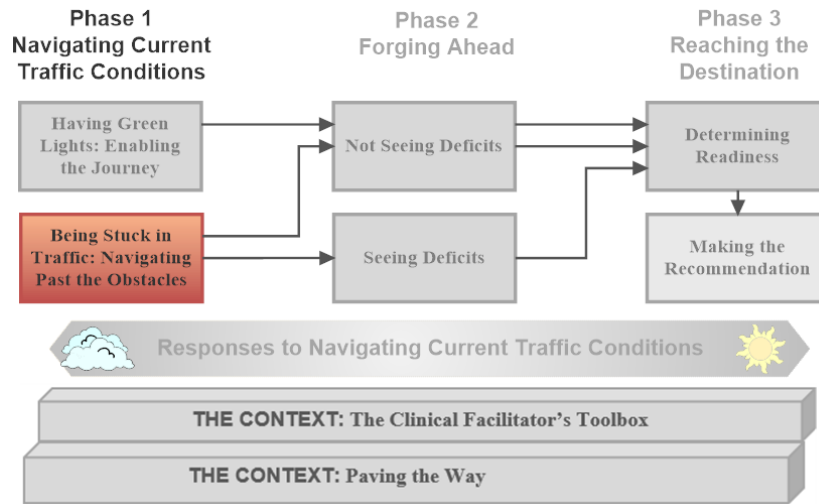


Figure 86: Being stuck in traffic: Navigating past the obstacles

The two sub-themes identified are ‘Responding to obstacles related to people’ and ‘Responding to obstacles related to resources’. Figure 87 illustrates how participants responded to obstacles associated with people and resources. Obstacles were related to students, workplace relationships, deficits in resources and mismatches between resources and practice.

The various processes used in the identification, assessment and management cycle are illustrated in this section. The colour scheme of pink and orange is used to illustrate the identifying and assessing of risk as these two aspects were closely linked. The blue shading illustrates how participants were interpreted as managing the risks to student readiness. The first sub-theme of ‘Responding to obstacles related to people’ is now described and interpreted.

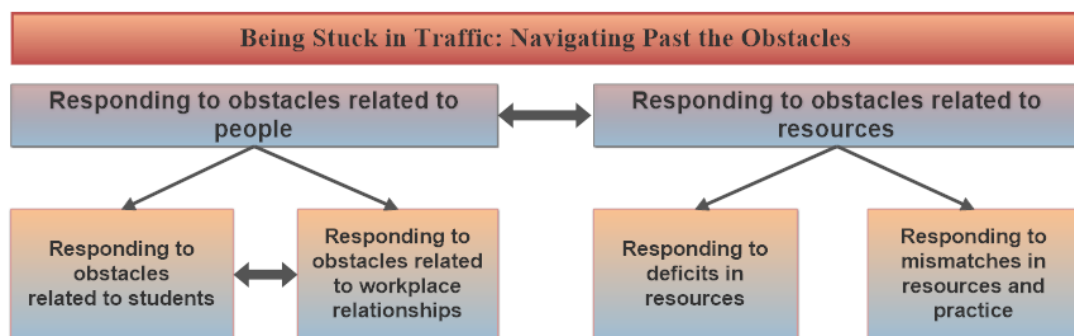


Figure 87: Responding to obstacles related to people and resources

5.3.1 Responding to Obstacles Related to People

‘Responding to obstacles related to people’ describes how participants perceived that obstacles to a student’s progression were related to attributes of both the student and HSS. To navigate past obstacles, participants described how they would actively engage in building relationships with both students and HSS to obtain better feedback and learning opportunities for students. When identifying the risk to students, participants noticed, found and linked obstacles that were likely to increase the risk to a student’s ability to be ready for the role of the RN.

Participants assessed that risk and determined they would need to act to mitigate for it. The two elements are titled: ‘Responding to obstacles related to students’ and Responding to obstacles related to workplace relationships’.

5.3.1.1 Responding to Obstacles Related to Students

Participants reported on the strategies they used to manage the obstacles they had encountered with students and other nurses. Participants described how they would actively engage in building relationships with both students and HSS to obtain better feedback and learning opportunities for students. Barbara reported:

I liken it to that they have learnt a certain way **of being**. So they've got a behaviour that they **come to the prac with and** sometimes that is **harder to work with** ... Whereas ... a younger, less experienced student they don't have a point of reference. They **don't already have a way of listening or already a way of being** and you can teach them.

These concepts are illustrated in Figure 88 and are interpreted as ‘Seeing “a way of being”’ and ‘Managing student obstacles: Getting in their world’.

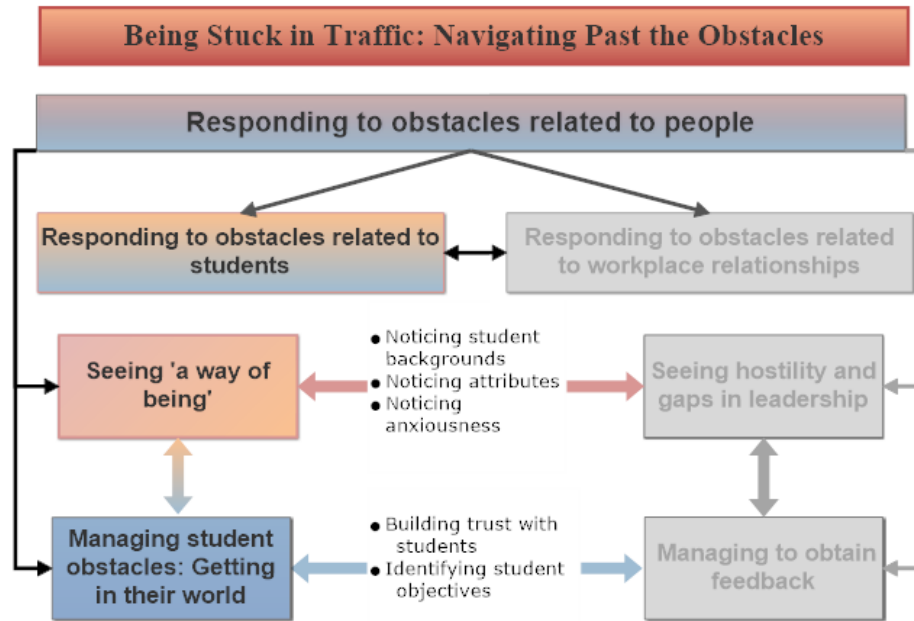


Figure 88: Responding to obstacles related to students

This element illustrates the risks to students’ readiness that participants had noticed (the pink and orange shading) and the actions taken to mitigate for that risk (shaded in blue). The arrow directions indicate that once ‘a way of being’ was seen and the risk had been determined, the risk was more able to be managed. Conversely, when participants took action, they were able to see other ways of being that would place students at risk. The first sub-element described is ‘Seeing a “way of being”’.

5.3.1.1.1 Seeing a ‘Way of Being’

Participants described attributes that would put students at risk of not becoming ready for professional practice. They described this as ‘a way of being’ where the attributes of participants were related to their ‘character’ and the ‘background’ factors that had affected students during their final placement. The personality and background attributes of risk included having a previous working background; having CALD abilities; worrying about other responsibilities; and being charming or manipulative, introverted or quiet, intimidating or anxious.

5.3.1.1.1.1 Noticing Backgrounds

Previous ways of working were beneficial to students and this was mentioned in Chapter 4. However, participants also considered that past experiences could negatively affect student readiness as students struggled with new ways of adapting

their behaviour or were overconfident in their ability to undertake patient care. These backgrounds were associated with a working background or a CALD background.

Elly reported that although some students had a working background as an EN, they faced obstacles when the supervising nurse was less experienced than they were in the care of patients. She relayed what students had said to her: 'I am coming to prac and doing what I would do and **not** getting paid and I feel like I am **supporting** the person who is supposed to be teaching me'.

To manage for this, Elly perceived this student needed learning opportunities that would be relevant to a student's 'toolbox' of experience. She reported on her first strategy:

So, we had to come up with, what's the difference between an EN and what's the difference between a RN, and **make up some objectives** for what she could get out of and how it can make her job **better as a registered nurse** and **not** focussing on the things that she could already do ... We **also** talked to the shift coordinator ... She went with a more senior staff member. We also even got her to work a day with the shift coordinator, so she **got** to see what the shift coordinator's role was and how it was different from the more junior staff. It was **also** positive in a way that she could see how hard it **was as a new grad**.

This narrative illustrated that students on final placements needed specifically tailored objectives to solve problems and to have effective communication and input from the clinical team. The practice of working with the coordinator or of coordinating the ward appeared to be outside the students' scope of practice. However, the support provided for the student was person centred and likely to extend the student in their ability to make decisions.

Another obstacle identified was seeing students struggle when they came with CALD backgrounds. In Australian health settings, students are expected to be fluent in their use of the English language.

Ashley also identified that her students were pulled from the health setting or given learning contracts when they had struggled with communicating and comprehending when English was a second language:

The first one went onto a learning contract ... I would just talk to them, ‘This is what you need to do, this is how you need to proceed with your patient’ ... So, there was **a lot of talk**, a lot of discussion, **a lot of coaching**, about what you are supposed to be doing. Certainly, **more than an hour** a day with those two.

Inadequate time to extend training was likely to increase the risk of not being ready for practice, but Ashley showed concern for students by giving them additional time. This narrative indicated that students with CALD backgrounds may have needed more input from the HEP about the Australian approach to nursing and training in idiomatic standard Australian English.

However, CALD students were not always received positively. Gemma reported:

Yeah, the international students um, who have **English not being the first language** have difficulty in communicating, **interpreting** what people are saying to them and can be perceived as being stupid ... I read the progress notes and I could see where they were coming from ... the other nurses (pause) took on board that English was **not** her first language and yeah, they saw her pulling her book out **every now and then** to look at things, which is great because she is doing something to develop it ... we **just addressed** getting familiar with terminology and um, abbreviations.

The perception of a student as ‘stupid’ was likely to bias an individual’s assessment of the student’s competence. This was likely to reduce opportunities to demonstrate their knowledge and ability to provide nursing care. In this situation, Gemma did not remove the student but gave the student the opportunity to become familiar with nursing and medical terminology. Without understanding this terminology, it was likely that the student would not become ready for professional practice.

5.3.1.1.1.2 Noticing Attributes

Participants had noticed specific attributes of students that would position them to be at greater risk of failing their final practicum. These risks were being introverted or quiet, charming or manipulative or aggressive towards participants or other nurses. Although the quieter individual was considered more at risk of not communicating patient care needs, these attributes could negatively bias HSS about their competent

practice. Gemma commented on how unfair assessments could be made about a student's progress:

Sometimes students are a **quieter personality**. That's perceived as standing back and not being interested ... the staff development nurse ... said to me 'Well, I **don't see her acting** as a third [year] student ... **She's always** following her nurse around. **She's a shadow!** And I thought 'all right, that is **not in sync** with what **I've been observing**' ... I've seen her do lots and lots. But then I spoke to her preceptors that are **actually working with her** and spend the **whole shift with her** ... she said, 'Oh no! From the entire students I've had she is the **most motivated to learn**. She has done **this and this and this**'.

Here Gemma appeared to struggle with this feedback about poor practice and managed this by clarifying the student's progress with others who had worked with her. Although Gemma had initially experienced some anxiety about this feedback, she was able to determine that the student was not at risk of failing.

Participants also perceived that students could be charming and manipulative. If students were struggling, their lack of competence would remain hidden from the assessor. Ashley also reported on the attributes of charm and manipulation:

This particular student was quite **manipulative** and charmed his way if you like through the prac so that when these issues did arise in the third week, it was, I thought, dopey putting him on a development plan [LDP] on the Wednesday.

The masking of this student's struggles meant that Ashley had not been able to identify that the student was struggling until late in the placement. When a LDP was given earlier in the placement, students had time to change their behaviour effectively. Ashley's ability to manage the risk appeared to have been hindered.

Participants also reported on the intimidating behaviour of students, which would affect them in becoming ready for professional practice. These behaviours had also influenced how safe other nurses and CFs felt about addressing and managing issues with students who were struggling. Elly described what the HSS had reported:

The students, they can be controlling to preceptors who do not have experience ... are unfamiliar with the paperwork ... and the students are leaning over them and they are saying '**Fill this in ... you have to put your signature here**', tapping

loudly on the desk ... They will give me feedback and say, 'I'm intimidated. I feel like **I can't be honest**, and **I can't write anything negative**' ... I will say to them, 'What you're verbalising and what you're writing are two different things' ... and they will say 'The student's always standing over me ... and I feel like they're pressuring me to write what they want me to write'.

If the student had not received verbal feedback prior to this stage, it was unlikely that they would be expecting negative feedback. However, when written evidence was not accurate about the progress of the student, the student was more likely to pass and not be ready for practice. Managing passive hostility from students towards CSs as necessary to obtain accurate feedback. Elly provided the staff with some strategies to use with such students:

So, I have to tell the preceptor, the ward staff to 'Ask for the paperwork. Ask if they can go to tea and you will fill it out in your own time to think about the paperwork' ... and it happens **all** the time. Particularly the um the students that are concerned that they're failing or struggling.

Gemma described how she felt personally intimidated or threatened by students who were struggling in their final placement:

Lots of stress sometimes ... When you are in a closed room like this and you are with a young male student who has **this large booming personality** I mean, [pause] it's a room that has **no glass doors** ... and **you don't know them** that well ... I said, '**I wasn't even sitting next to the exit**'.

In this context, privacy appeared to be less critical when students were volatile or threatening towards facilitators. Having stresses like this might indicate why some facilitators turned away from raising issues with students who were struggling and may have needed to consider the mitigating risk to their personal safety by having these conversations with someone else nearby or with them.

5.3.1.1.1.3 Noticing Anxiety

Participants noticed when students were anxious. Associated with anxiousness was a student's mental health history and if they had previous negative experiences in a clinical placement.

Some students experienced situations where they needed to protect their mental, physical or emotional safety. Harry recounted that it was typical for a student's previous mental health issue(s) to surface before or during a mental health placement. Harry reported:

I know of four that are struggling with severe mental health problems ... when it comes time to the lectures ... I get numerous 'I really can't come to my lecture. This is going to cause me problems'.

Students who did not attend specific lectures that would prepare them for providing care for patients with mental health needs were at increased risk of not being ready for the role of the RN. In contrast, some students were prepared for the mental health setting, but still struggled with clinical situations. Harry reported of one student, 'She just had no coping strategies'.

Students who had poor coping ability had issues with attending mental health placements or with events that triggered student reactions. Anxiousness in students appeared when they were concerned about their physical needs. Harry reported on a conversation with his student:

I don't know if I am going to be here tomorrow'. And I say 'Why's that?' And she said, 'Cause I've got nowhere to live and I'm living in my car from tomorrow'. **Really!** So that becomes problematic.

Harry was asked, 'So, how did you manage that?' He reported:

Basically, I had to spend a couple of hours with her and again it's very difficult when you start prying into people's lives, isn't it? ... So, the first question is 'Is there anything I can do to help?' It was quite a [sigh] difficult episode for a week ... It's quite worrying going home and thinking I don't really want a 19-year-old female student sleeping in a car ... It was then a case of going back to the university and going to look at whether there was accommodation available, where was she going live, what was she going to do? It was quite a [sigh] difficult episode for a week. (yep) It kind of sorted itself out in the end ... Daily phone calls, (yep) and um, she was also having to **contact me** at the end of each shift whether it was an early or late shift so that I **knew** she was going okay and that she was okay. But that was all, **all I** could do really.

Harry relayed the importance of having access to the supportive services of the HEPs. He also highlighted this type of additional support was difficult to provide. However, the support appeared significant in assisting the student to get past the obstacles. In the example provided by Harry, he appeared to monitor not just the student's ability to practice professionally but, at the end of the shifts she had worked, had monitored her emotional state. In using HTMETS to interpret this narrative, Harry's concern was not only with the student's placement, but with what was happening in their personal lives. He could choose 'one's way and win', (Figure 20, HTMETS #15), be a "person-in-relation" attuned to a quest for benevolence' (Figure 20, HTMETS #13) or have 'genuine ownership of a way of thought' (Figure 20, HTMETS #2).

Students were found to worry about other responsibilities not related to their placements. During the placement, the student had to manage not only their practice but also their other (external) affairs. These responsibilities included university assessments, attending to family issues and working elsewhere to meet financial obligations. Barbara reported on factors external to the student: 'I find the students who are struggling ... **often** it's to do with **outside external** factors. So, things that are going on at **home**, things that are going with **families**'. She also referred to students' prior practicum experiences:

If the student has had a negative experience prior to coming to their final semester ... they are **very anxious, and they are over compensating** and they are worried about failing ... 'This is my final semester and I am going to do what it takes' ... **They're highly organised** ... They are **very task orientated**. They sometimes can be seen by the other staff as being too assertive. They don't fit into the team.

Being anxious and too assertive were attributes that were more likely to result from negative experiences. Anxiety shifted a student's focus away from providing total nursing care to that of doing tasks and nurtured isolation from the clinical team where decision making could be observed and practised. Knowing this assisted Barbara in the identification and assessment of the risk.

In summary, participants identified that the obstacles to a student's progression were related to students' backgrounds, attributes or how anxious they were. For participants to be able to identify these issues students needed to be open about them, HSS needed to report what they had observed and CFs needed to notice, link or see issues when

students struggled. A student's and participant's anxiety was influenced by the quality of the workplace relationships and the CF's relationship with the student and HSS. When struggling students were not open about their concerns, the risks were more likely to be identified too late.

5.3.1.1.2 Managing Student Obstacles: Getting in Their World

This sub-element 'Managing student obstacles: Getting in their world' describes how participants valued their relationships with students who were on a final placement. Most participants reported on the need to identify and determine the risk about a student's background to assist them in moving onwards. The two aspects to managing were 'Building trust' and 'Identifying student objectives'.

5.3.1.1.2.1 Building Trust

Participants initially managed by asking key questions about background experiences and expecting that each student would have specific learning objectives. Barbara reported on the benefits of exploring a student's background experiences:

[long pause] I got in their world. I think it's like, to get an understanding as to why or where they came from, what their experience was ... and what their background was and whether they had positive or negative experiences ... Because if you **don't**, if you **haven't got that rapport with them**, that they feel comfortable with you telling you everything you are not going to get to the bottom of things and you are not going to help them get through ...and that's when, you know, they'll see that I'm on their side and I'm their facilitator and **not** the big bad 'ogey'.

Barbara built rapport with students to get them to trust her. I used HTMETs to interpret the narrative, Barbara 'assumed control of situations with resoluteness and dedication for one's goals' (Figure 20, HTMETs #12) as she focussed on understanding the students' need for support. She was a 'Person-in-relation' attuned to a quest for shared community values for achievement (Figure 20, HTMETs #13) so that the student would make it through the placement.

Elly also built rapport with students to build their trust in her but was more hesitant about asking students questions before establishing the trust. She reported:

So, with my final-year students ... The first thing that I do is make sure that they **trust** me so I, I never want to **jump** on them [smiling] and just start asking them a whole lot of questions ... I get them to explain to me what they have been doing and what they feel they **can** and **can't** do ... I try and help them, so give them resources.

In summary, building trust and monitoring progress were found to be the platforms from which the majority of participants could assess the risks. Asking these questions and identifying the learning needs of students was a way in which participants could 'drive' the student onwards in their final placement. When participants asked students a specific question about their backgrounds or other significant events, they were able to identify what the risks were, assess the effect of the risk and plan to manage this risk.

5.3.1.1.2.2 Identifying Student Objectives

Returning to the metaphor of driving, a student's objectives could be described as a 'map' as they provided the direction for the student. This map provided specific nursing care skills that students needed to achieve each shift or each week. Upon reaching these objectives, new objectives would be determined and were used as a guide to steer students onwards. Participants used specific questions to determine what the student's plans were for the future or the present placement. The types of questions that Barbara asked were, 'What have been some of the challenges that you've had?', 'What are some of the good things?', 'What do you want to do when you graduate?' and 'Where do you want to work?'

Barbara was asked by the interviewer, 'Why do you do this?', to which she responded, 'Because if they are not interested in where they are, often they won't perform'. Being interested in the clinical specialty appeared a key consideration for Barbara. For the final placement, Barbara expected to understand what learning objectives were essential to the student:

I ask them to write down their objectives, so they do have objectives and it, depending on which university they go to you have learning objectives or learning outcomes. So, I actually **ask** them to write their learning objectives.

Ashley also reported, ‘I **often** sit with students and help them set those objectives based on concerns that they have or experiences that they want’. As the participant guided students to set weekly objectives, she could monitor this progression.

In summary, participants considered the developing trust with students was essential to helping students be open about their needs and minimising risk to the student’s readiness. Although participants wanted to know what objectives students aimed to achieve, they would also assist the student in defining objectives. By managing student obstacles and getting in their world, they could obtain further insight about a student’s ‘way of being’. This way of being could be influenced by the hostility shown to them by other nurses.

The next element describes how participants sought to steer past negative workplace relationships and assist students to reach their learning objectives; it is titled ‘Managing obstacles to workplace relationships’.

5.3.1.2 Responding to Obstacles Related to Workplace Relationships

This sub-theme describes how at times the relationships of HSS with students and participants appeared fragmented. It also outlines how difficult it was for CFs to obtain feedback about struggling students and describes the strategies the participants implemented to circumnavigate hostility. Elly reported:

To be able to do your job. Cause you can’t do it in isolation ... But, see the more I am doing this job, the more I’m realising it is, is more about the relationship between the facilitator and the staff to make things work well. So, you have to have an open relationship so that they can communicate safely ... you learn the coping mechanism, you always smile; you have to break down those barriers so that people trust you and know that you are there to support them.

Figure 89 illustrates the sub-elements of this theme and shows how participants noticed that there were gaps in the clinical leadership of the workplaces (pink and orange shading) and the action they took to manage the relationships (shaded in blue).

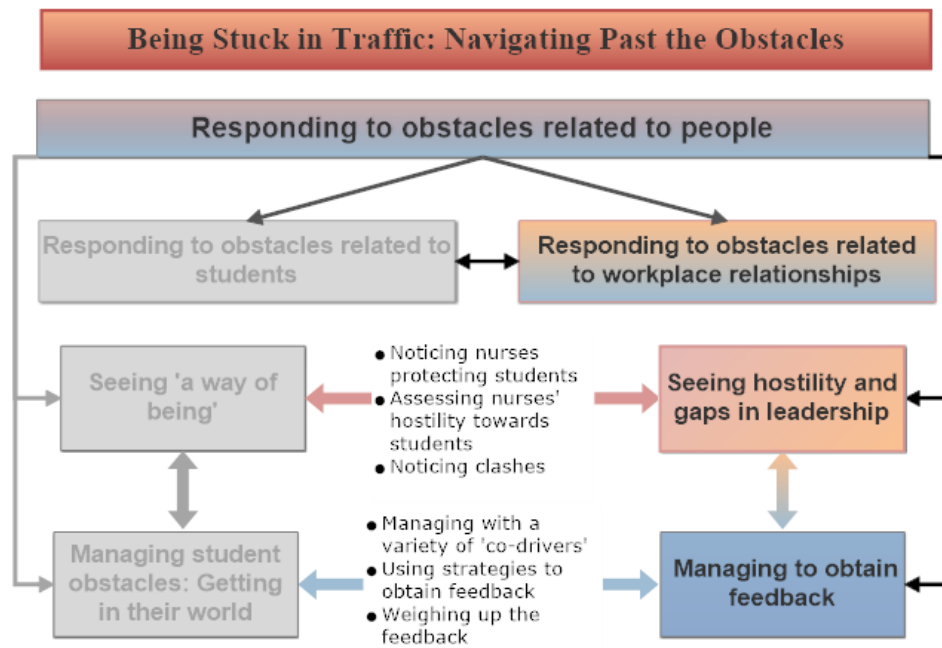


Figure 89: Responding to obstacles related to workplace relationships

The arrows indicate the interrelationships among the concepts that enabled participants to I, A & M. The sub-elements of responding to obstacles related to workplace relationships are titled, 'Seeing hostility and gaps in leadership' and 'Building the relationships to obtain feedback'.

5.3.1.2.1 Seeing Hostility and Gaps In Leadership

This sub-theme describes gaps in leadership that participants experienced when supervising students on a final placement. Gaps in leadership occurred when there was a lack of professional modelling, students were not valued, CSs were unprepared and participants did not invest in building relationships with other nurses in the health setting. A gap in leadership also led to 'co-drivers' such as HSS, students and participants experiencing mutual hostility and having a clash of personalities. The aspects that describe this are 'Noticing nurses protecting students', 'Assessing nurses' hostility towards students' and 'Noticing clashes'.

5.3.1.2.1.1 Noticing Nurses Protecting Students

This aspect describes how participants reported they could not obtain feedback from HSS about the progress of struggling students. When students were not reported as struggling the CFs were not always able to manage the risks associated with the student's progression.

Participants recounted instances where nurse supervisors did not report students who struggled. This was to protect either themselves or the students who were on a final placement. When HSS did not provide feedback about students who were struggling, they were seen to protect themselves from having to do additional work. Ida reported:

So, some of them will not say anything ... The staff going 'don't worry about it. (whispering) It's **fine**'. And the student would continue to make similar mistakes but get away with it cause often the staff would say 'Oh, I don't want to report that because then I will have to fill in risk man da di da di da' (sing-song voice) and **that happened a lot** ... staff would cover it up. Not always helping cause, then you didn't deal with the issues and make sure that the student **understood** the implications of what they'd done.

Although this behaviour reduced the supervising nurse's workload, it was likely to increase the risk of unsafe nursing care in that such students had an increased opportunity to pass the final placement without being ready for practice. Ida reflected on how this practice did not help the student nurse to develop.

Elly reported that younger supervisors would turn away from giving feedback to her as they wanted to protect the student. She reported:

If you've got a grad nurse that's **similar age** to the student ... So, they **see them as** you know, someone that they want to protect. They will say, 'Look. I **don't want** them to be in trouble'. So they think that if **they tell me a negative** about the student and they think that I am going to tell them [the student] off or fail them rather than them seeing it as a positive. If they [nursing supervisors] can identify what they [students] are struggling with **early**, then I can put things into place at an **earlier** level ... They see me as someone that's a **bad person** in a way ... But I **want** them to see me as someone that is a **positive and** I can **fix or help fix or identify** the problems. To **help get them** [students] to be in a better position at the end of their placement; so that they **are** ready.

When the need for action was not recognised, the CFs were unlikely to implement strategies in a timely manner to change the student's behaviour. Keeping hidden this information from the facilitator would hinder the student in becoming ready for professional practice.

In summary, if struggling students were not reported, they were likely to be recommended for nursing registration but would not be ready for professional practice. HSS who did not report struggling students were more likely to place themselves and others at risk as the student had not had an opportunity to correct their nursing practice. A further factor of risk identified was the hostility shown towards students.

5.3.1.2.1.2 Assessing Nurses' Hostility Towards Students

Having supportive relationships with professional nurses was identified by participants as being significant in assisting the student to become ready for the role of the RN. However, participants identified that some HSS appeared hostile towards students on a final placement. The areas where hostility was identified were areas related to general hostility, CALD and personality clashes.

Participants described how hostility had occurred within certain specialty areas. Caroline's expertise was in the theatre area and she had been employed to be present during the complete theatre shift that students worked. Caroline recounted a situation where the nurse supervisor had not been expecting a student in her theatre:

Now this girl, she goes 'I wish somebody would speak to me before they put the student in here' ... She came in and said, 'You, sit on that stool over there' ... But you see, immediately **I take them out of there**. I just go and say, 'Look I am taking my student elsewhere' and I take them out and I'll go to the staff development nurse and say, 'This is what's happened'. They're **not going to** learn anything sitting on a stool in the corner. I mean, **how embarrassing is that** ... Theatres are the same ... you've got toxic people in it ... There's a lot of bullying in nursing and as they say, 'nurses eat their young'. It's horrible isn't it? ... I've **also experienced it** and **I don't like it** and there's **no need for it**.

It is likely that Caroline was sensitive to issues of bullying as she had experienced it herself and it also could be argued that this had influenced her perceptions of risk for student learning and inclusion. The CF would need to make an accurate assessment of the extent of bullying that a student was experiencing to assess the risk. Caroline identified that when students were isolated from the team, they were at risk of not developing their confidence to interact and provide care as part of the team. According to HTMETS (Figure 20, HTMETS #13) Caroline was a 'person-in-relation' attuned

to a quest for fairness, dignity and achievement. It was likely that CFs who performed the 'liaising' role would not be as effective in identifying or managing for these types of risks.

Another population found to be vulnerable was CALD nursing students. Participants described their lived experiences of dealing with hostile or biased workplaces. Debbie reported, 'There are prejudices with different, especially where there a lot of Africans that are doing their training ... As far as I was concerned ... I know in this particular hospital they weren't very well received'.

Debbie was asked, 'And how do you manage that?'. She replied:

I let it go until they, until the staff can see that that student knows what they're doing ... they should still be given the courtesy (yeah), but it's hard, hard you know, to come in on that ... I'll go to the manager and say 'I don't want my student with that person' ... **I don't think it's up to us to actually have anything to say to that preceptor.** I think it's up to us to speak to the manager and for the manager to go back and speak to them, cause **they're her staff.**

Watching and waiting was a process that Debbie utilised. This action indicated that she was giving the staff the opportunity to assess the student accurately. However, she was not afraid to intervene and seek solutions with senior staff members as needed and demonstrated that she 'can choose one's way and win' (Figure 20, HTMETS #5). In managing for this, Debbie did not have discussions with supervising nurses about their biased assessments or how they may have limited the student in having learning opportunities. In this instance, where CFs reported issues to a senior member of the health setting team, they were relying on this member to solve hostility issues related to not just an individual but to the team of HSS. According to HTMETS (Figure 20), a hermeneutical turn of the participants had occurred when participants turned away from being open with the CSs who were working with students and instead focussed on establishing relationships with ward managers. Debbie felt that managers were responsible for dealing with staff hostility and saw this as the boundary for dealing with issues.

In summary, factors that increased the risks to final-semester nursing students' ability and anxiety levels included HSS hostility towards students. Hostility towards students

also increased the participants' workloads to make a fair assessment about students' competency. Removing students from hostile environments was one way that some participants managed.

5.3.1.2.1.3 Noticing Personality Clashes

Having supportive relationships by professional nurses was identified by participants as being significant in assisting the student to become ready for the role of the RN. However, participants identified that students had expressed they had clashes with other nurses and CFs. The participants also identified that other nurses had clashes with them. Barbara recognised that she could not solve personality clashes for students, but that she could try and bridge for a personality clash. She reported:

I wanted to know **what was it about** her relationship with the clinical facilitator that **clashed** ... and, it was personality ... I asked her, 'What ... do you need to do to know that you're going to **pass** this prac?' ... She needed feedback from me **verbally** but ... she wanted to know about it straight away ... '**Don't wait until 2 days later**. If I am not doing something properly or if there is something going on, or if staff complain, **you have to tell me**, so that I can do something about it'. Now there might be personality clashes with their preceptor, but they **grow** from that ... 'so **how** can I help you work through that? That's what I'm here to help you do'. They've got to start thinking about ways of managing that.

Interestingly, the label of a 'personality clash' appeared to refer to conflict in the processes that were used that appeared to place the student at risk. Barbara managed students by identifying their needs, expecting them to look to the future and expecting them to deal with 'personality clashes' as they occurred during their final placement and to prepare them for registration. Here Barbara was seen to be future orientated (Figure 20, HTMETS #11).

Another process that caused HSS to clash with CFs was the removal of students from clinical areas during critical times in nursing care. Ida reported:

the supervisors saw their role as to do these education sessions ... they've [students] got to be with their preceptor or buddy to be with their patient and to do the **ward work** ... But when the outside supervisor comes in, often they will dictate that they want to see all their students all together ... Now they've all **had patients** in the

morning and there's the handover to be given at 2 pm and they're nowhere to be seen. And staff get **understandably upset**. Cause they're not fulfilling their role; they are not doing the complete job and they have to do the handover.

Removing students from attending to clinical duties was seen to hinder students from having the opportunity to increase their skills: writing up patients' progress notes, completing any other documentation and being preparing for and giving handover to the incoming staff. To manage this clash, Ida insisted that CFs avoided removing students from specialty areas. She reported:

I used to say to them, '**No, you can't take them away**' because that meant that they met **all** of them rather than going around on individual wards and it was a shortcut method to see them all.

Here Ida also interpreted a CF's process of having group meetings with students as a way for CFs to avoid spending time with individual students. This perspective highlighted how HSS doubted the intentions and processes of CFs to nurture and support students.

In summary, clashes and gaps in clinical teams occurred with CFs when students and HSS had differing expectations about supporting students on a final placement. It was indicated that CFs may need further collaboration with HSS and students about the processes they used to support students on a final placement. Without this knowledge through active engagement with HSS, the CF was likely to drift along with the 'humdrum routines' role of facilitation (see Figure 20). Drifting in this mode of engagement was likely to heighten hostility towards CFs or students. CFs needed to build relationships with HSS to obtain feedback.

5.3.1.2.2 Building the Relationships to Obtain Feedback

The participants indicated it was essential to build relationships with HSS. Without accurate feedback, participants felt unable to adequately support struggling students. The aspects of this sub-element are 'Managing with a variety of "co-drivers"', 'Using strategies to obtain feedback' and 'Weighing up the feedback'.

5.3.1.2.2.1 Managing With a Variety of ‘Co-drivers’

Participants had to deal with a variety of ‘co-drivers’ to obtain feedback: the supervising nurses, SDNs, CNs, placement officers, nurse managers and students. Ashley reported on managing with a variety of ‘co-drivers’ through sharing information and providing the additional support of recommending students for employment:

It **usually** comes, it is **usually** shared. I might recognise **something**, or the unit might report to me. Usually it doesn’t come as a surprise ... I think that it's very important to be visible **in** the hospital **on** the unit. Whether it’s just interviewing the student, I think it’s a big part of being interactive with facility staff. That’s how I have built my credibility in the facilities ... When it was asked of me by the hospital, I gave a glowing reference.

The sharing of issues showed collegiality between the participant and HSS in managing with a variety of ‘co-drivers’. The endorsements of well-performing students to the HSPs suggested that there was an element of trust in the relationship between them.

Ida also valued the input from senior members of the health setting:

I would always go to the SDNs because they were the ones who would hear the rumblings ... it’s like checking the temperature. ‘Oh good’, ‘Oh satisfactory’ or ‘Not too sure’; then I would investigate more. But I could tell how things were going because the SDN hears what staff in the tea rooms are talking ... So, some of them are more involved than the others and particularly if they have a different preceptor every day.

‘Ward talk’ was more significant when students had a different preceptor or supervisor for each shift they worked. It was possible that ‘ward gossip’ could form biases about a student’s level of competency. In cases where bias may occur, it was possible for students to be considered struggling. Some participants turned away from relying on their preceptors for information about a student’s progress.

Barbara also identified that when she built a relationship and support with senior members of the HSS, she would use strategies to minimise mismatches about facilitation and communication about student issues. Barbara reported:

When I go onto a ward, I find who the unit manager is, introduce myself to them. I find out who the clinical nurse specialist is, I go and meet the staff development nurse ... I give all of them my mobile phone number and make it really clear that I am available, but that I also set up a conversation ... what the avenues are to address ... I ask them what they see my role as, cause I think it's important for me to understand what they think my role is; not just what I think it is.

To ensure other nurses would provide feedback about a student's progression, the participants sought to build their relationships with nurses who not only managed students but who had supervised students. They used specific strategies to obtain feedback.

5.3.1.2.2.2 Using Strategies to Obtain Feedback

The strategies participants used to obtain feedback were related to planning for workplace factors, ensuring confidentiality of information and identifying how to obtain accurate feedback. Some participants assessed that HSS would open up about struggling students if they were given reassurances that the information would be confidential and if CFs asked question at an appropriate time during the shift. Barbara stated, 'Once you ask the staff one on one and you explain its confidential and won't go any further, they will often disclose more information'.

Gemma provided some insight into how she had approached HSS when they were not busy:

If I find that they are standing around idle, or they're not doing anything related to patient care, I will say, 'Do you have two secs? You've been working with this person for a few days now, how how's it going? Any issues? Any concerns?'. And some of them will say, 'No all good'. Or sometimes they're not sure. Sometimes, 'Just this little thing ...' So it's just finding the right time to speak to them when they're on the floor, because obviously they're run off their feet.

It appeared Gemma was conscious of HSS workloads and consequently waited for HSS to be available before she spoke with them. Not wanting to intrude on the supervising nurse's time might indicate that questioning staff about students' progress was kept simple and questions about the progress of students appeared to be broad.

Elly described the range of questions she asked other nurses:

We need to be very organised with our questions. So, for example, I will say ...
'Can they take a patient load?', 'Have they been able to handover to oncoming staff?', 'What do their notes look like?'. So, I have to give them actual questions ...
It's not about them as a person; it's about all the things that make them a good nurse.
And where you can come in and support them and help them.

Elly suggested that asking specific questions would lower the risk of not having accurate feedback about a students' progression. Her passive approach to HSS was a gentle reminder to redirect the CS's focus to performance rather than personality. This was likely to de-escalate inaccurate reporting, increase HSS credibility and alert the CF of real issues about student progression.

Ashley also asked her students to ask specific questions to obtain feedback, '**I ask the students to obtain feedback** at the end of their shift; "**What** went well?'. The more specific the question, the more likely the student and the health setting staff were likely to provide feedback that was more descriptive and objective about the student's progress. Although participants used specific strategies, they reported they needed to weigh up the feedback against the evidence they obtained about a student's progress.

5.3.1.2.2.3 Weighing up the Feedback

Participants valued feedback but some learnt they had to make a judgement about this feedback. The weighing up of the feedback was needed to ensure that the risk to the student's progression was accurately identified. They would evaluate the feedback against what they knew about staff, their assessments of students and workplace cultures: they weighed up the evidence. This was done through knowing whose feedback to trust, reading the students' written reflections in the NCAS and by working with students.

Ashley reported:

I know a lot of the staff, so I can trust, or find the person I am looking for and then trust the feedback that they're giving and pretty quickly learn who's giving genuine feedback, or who might be giving feedback based on a prejudice or bias because the student's got a personality problem or something. So, it is weighing it up.

Ashley was also conscious that students needed to be assessed on their ability to perform professional nursing care, not on their personality.

Debbie described how she had assumed that the feedback from HSS was accurately representing a struggling student, but in hindsight and discussion with colleagues had realised that the student was in an environment that was not supportive of him. Debbie reported:

She [the supervising nurse] was complaining about the student but then she doesn't realise that she was the one that was at fault either. So, **you've gotta see two sides of that**. And then I would go ... and work with the student just to see what, what they're saying to me is true ... Well, **it made me feel guilty** that I was **assuming** this other student from earlier on wasn't as good **as what he was** because he was with her. And when he was with other preceptors, he was fine ... And so, **what made me feel really guilty** for this third-year nurse was that **I didn't go** and speak to the manager before. **I was going to and** I thought 'No, no, no, it's just him'. Not knowing the whole story of the other ward staff and what they felt as well ... But what has made me **so cross is that she has gone** and had another student ... I would **go straight to the manager next time**. I wouldn't hesitate.

When Debbie had become aware of HSS bias, she had experienced a sense of guilt. Debbie recognised her responsibility to offer students on a final placement a fair and accurate assessment about their nursing care. The act of relying solely on the biased feedback of a staff member had reduced the quality of the journey for her student. Debbie had turned towards using managers to obtain feedback and deal with issues related to nursing supervisors. In HTMETS, Debbie saw that the way she had 'identified' struggling students or 'trusted' feedback needed to be improved. She turned away from taking one assessment (Figure 20, HTMETS #35) towards seeking input from a variety of nurses. She became 'a 'person-in-relation' attuned to a quest for shared community values' (Figure 20, HTMETS #13). Being fair about how

students were determined as safe to practice was a key factor in seeking input or evidence from nurse managers and others.

Although participants described senior staff members as being the most reliable source of information, not all senior staff were unbiased or receptive to students. Fiona reported that in one health setting, the ward culture was not receptive to students. She reported, ‘I felt them [HSS] quite cool in manner towards them [students of CALD] ... in **this particular hospital unit**’. There was a sense that Fiona considered that staff bias would affect the quality of assessments. This was likely to suggest that she would weigh up the evidence that was presented to her.

In summary, the element of ‘Responding to obstacles related to workplace relationships’ identified gaps in leadership. Participants dealt with a variety of ‘drivers’ and valued the reliable feedback of senior staff. The least reliable source was nursing supervisors who would protect students from CFs or who felt they needed to protect themselves from additional work or take on the responsibility for reporting the student’s struggle. The risk to readiness was increased when CFs relied solely on one person’s feedback rather than on the collection of information. The participants learnt to weigh up the evidence about risks. In cases where students were not managed by HSS, participants had spent increased amounts of time to identify and resolve learning issues for struggling students.

5.3.1.3 Summary of Obstacles Related to People

Participants identified that the likelihood of risks to readiness increased when HSS saw CFs as a threat or had a workplace culture of hostility towards students. The significant effect of workplace relationships was that participants struggled to obtain accurate feedback and if the problem was identified late in the placement, participants were unable to put timely strategies in place to I, A & M this situation. The lack of feedback made it challenging to manage the opportunities for students to obtain the learning or practice they needed to become ready for professional practice.

The ability to obtain feedback was dependent on the use of strategies to bridge for gaps in workplace relationships. By building these relationships to attain feedback, participants were able to gain insight into the students’ world and to see further risks. Participants learnt to weigh up and assess the quality of feedback and the quality of

the assessor. They utilised questioning techniques to obtain accurate feedback about student competency. When participants identified gaps in workplace relationships, they could understand more about why students were responding the way they were, which provided them with insight into how best to manage them. Participants appeared to be ‘future orientated’ as they considered strategies for problem solving and built capacity into the support they provided to the workplace.

The next theme ‘Responding to obstacles related to resources’ describes how participants identified obstacles in the resources used by both HEPs and the HSPs, and how they managed for these obstacles.

5.3.2 Responding to Obstacles Related to Resources

The sub-theme of ‘Responding to obstacles related to resources’ describes how participants reported that HSP and HEP resources had hindered students in becoming ready for practice. When providers did not have appropriate or sufficient resources to assist student progression, participants had found it more difficult to manage for this risk. Participants described how they had responded to deficits in resources and to various mismatches between resources and practice. The two elements illustrated in Figure 90 are titled ‘Responding to deficits in resources’ and ‘Responding to mismatches in resources and practice’.

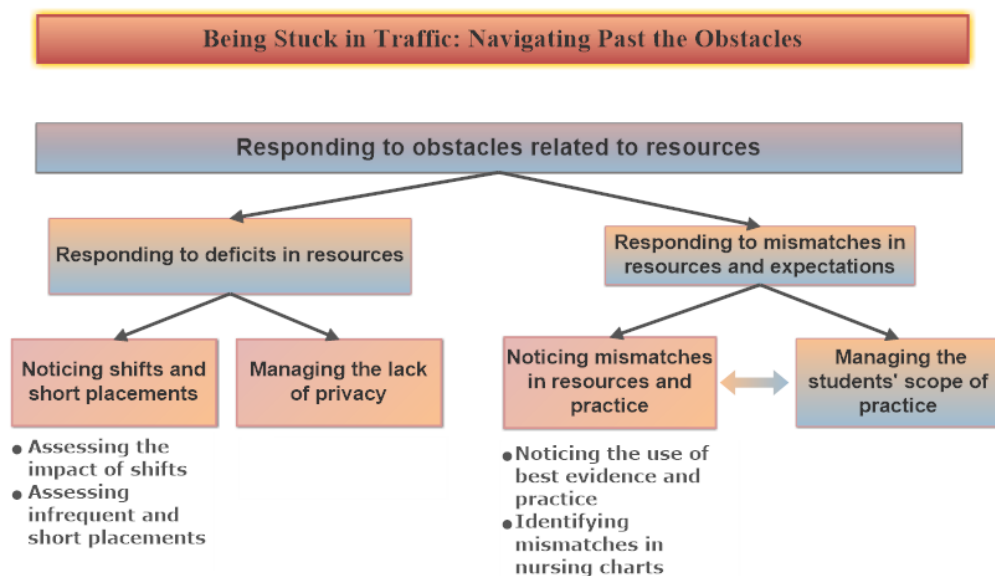


Figure 90: Responding to obstacles related to resources

5.3.2.1 *Responding to Deficits in Resources*

This element outlines how resources were seen to be inadequate to meet the learning needs of a student on their final practicum. These deficits were related to insufficient access to resources, which would reduce the ability to provide students and participants with effective CLEs. Debbie stated:

you get a third-year student doing a last prac who has never worked in a hospital before ... I know it can't be helped because there are not enough placements and it's even going to be worse next year ... I then let the ward staff, or the manager know, or whoever is supervising that day, in charge that day, that the student has not been in a hospital before and to go easy on them.

The two sub-elements are titled 'Noticing shifts and short placements' and 'Managing the lack of privacy'.

5.3.2.1.1 Noticing Shifts and Short Placements

The participants described student learning was at risk when the allocated shift did not give them enough exposure to learning, when their supervising nurse worked short shifts and when placement periods were of short duration. Caroline reported that on evening shifts, 'It is a disadvantage to be on evenings, on the same shift all the time'. Elly identified that learning opportunities could be obtained by working the evening shifts; it was dependent upon the setting. She reported:

So more medical wards I think they're [students] more at an advantage at being on an early shift, but the surgical wards are still as busy in the afternoon with patients coming back from the theatre ... they've got shorter shifts ... So, they only work 7-hour shifts and there is **no crossover period** ... **I feel** that the shorter shifts **do affect** the students' time with their preceptors ... it **is a risk** to the student, which they are **not** getting the amount of time to debrief at the end of the day ... Feedback needs to be given **daily**. The notes **have to be countersigned** ... So, then I'll come along and say, 'Look, did you get to do your two notes?'. And they'll say, 'No, because my preceptor's gone home. I'm here for another hour but I **can't do** my notes because no one else worked with me' ... I'm finding that the paperwork that is done is **rushed** because the student's more or less just popping it under their nose and it's, it's **not looked** at as a priority for the staff member ... then it gets to the point

where the preceptor wants to take the paperwork home to do it in their own time because they have run out of time.

Knowing how placement specialties or shift times affected students' opportunities to learn was likely to assist the CF to monitor how students were learning. A further concern was where students did not work with anyone during the shift 'crossover period'. When students and nursing supervisors had differing priorities about when the NCAS should be completed, it was likely to increase anxiety for the student. Although this document was taken outside of the workplace, the participant did not say how this might put the student at risk if the document could not be retrieved.

Placement opportunities were a resource that participants recognised were in short supply. Participants determined that infrequent and short placements had limited students' ability to consolidate their nursing practice. However, shortened placements or long periods between placements were identified as obstacles when students were in their final placement. Barbara also felt that the time allocated for a final placement meant there was little time for the student to socialise into the workplace and develop their expertise. She reported:

They are on very short placements. So, there is a **very short time** period that they've got to learn you know, the **culture, practice** their **skills**, get an idea of what the **attitude** is. You know, their **expertise**. **There's a lot of overload**.

In summary, short and infrequent placements were identified as putting students at risk of not becoming prepared for their final placement. Participants managed the lack of privacy by seeking out alternative places to support students with privacy. Participants had assessed and monitored shifts that provided students with learning opportunities. Participants perceived infrequent and shorter periods of placements would negatively influence how students could adapt to the working environment and consolidate their knowledge.

5.3.2.1.2 Managing the Lack of Privacy

Participants had managed for lack of privacy to identify the issues students experienced. A meeting room was likely to provide privacy and increase the openness of staff and students to discuss these issues. Ashley was asked, 'When you are

assessing students, what sort of things enable you to assess a student effectively?'. She replied, 'Somewhere where you can do it in private'. Caroline similarly reported: '**Oh yeah. Oh yeah.** You **can't openly** discuss this in public, particularly if there are problems with other people listening to you'. Obtaining privacy for students appeared necessary to identify the risks and determine what actions were necessary.

Participants described how they sought places where they could converse with students in private. Gemma explained that meeting rooms were available in some settings, but arrangements needed to be made ahead of the required time at which they wanted to meet with students. She reported:

There's always rooms like this that you have to **book** or you know, talk to someone up in offices behind closed doors ... So, a lot of times I was using the café and stuff at [HSP#5] and when students get upset [quietly spoken] it is so **awkward, and** they start crying ... and there was **no** room anywhere and I actually took her to my car and said, 'I'm sorry, but we will go to my car'. Because I knew, she was going to get upset.

Her tones were anxious and half apologetic as she explained the need to seek the privacy of her car. I used HTMETS to identify that Gemma had made a turn away from discussing issues with struggling students in public spaces to reduce the distress to herself. Discussing issues in private was also likely to have reduced the distress to students. The interpretation of Gemma's actions where she 'turned away' from using public spaces, was one of taking 'assume[d] control of situations with resoluteness and dedication for [her] goals' (Figure 20, HTMETS #12) to lessen the threat of distress and to manage risk.

The next element of 'Responding to obstacles related to resources' is 'Responding to mismatches in resources and practice'. This concept describes how students could be challenged by HSS when their practice did not align with the expectations of HSS or the participants.

5.3.2.2 Responding to Mismatches in Resources and Expectations

'Responding to mismatches in resources and practice' describes how obstacles related to resources and practice in health settings did not match what students had been taught by their HEP or what was expected from the HSP. Ida stated 'I understand the

student's frustration because they will often have more evidence-based practice and up to date knowledge than the hospital depending on whether they consider policy development as significant and worthwhile'. The two sub-elements are titled 'Noticing mismatches in resources and expectations' and 'Managing the students' scope of practice'.

5.3.2.2.1 Noticing Mismatches in Resources and Practice

Participants described mismatches in the tools and parameters that were used to teach students and those such as nursing documentation and assessment parameters used in individual health settings. Although HEPs taught students about the 'safe parameters' to use in physical assessments, these parameters appeared to vary across health settings. The concepts are titled 'Noticing the use of best evidence and practice' and 'Identifying mismatches in nursing charts'.

5.3.2.2.1.1 Noticing the Use of Best Evidence and Practice

In some cases, the best standards of practice were not known to all HSPs and students had to revert to older standards used in a health setting when practising clinical skills. This mismatch of expectations was related to the rolling out of new standards across Australia and when the HSS did not update themselves on recent changes to policies in the health setting. Participants managed for these mismatches by recognising how mismatches occurred and by providing students with a rationale for the mismatches between practice and new evidence.

Elly described how she identified that a mismatch had occurred when the DOH had rolled out a new policy for administering intravenous antibiotics. This approach, the 'aseptic non-touch technique' (ANTT) was to be used by nursing professionals and students. Elly described these issues with ANTT in the following way:

Aseptic non-touch technique. (yeah) So that **has affected a lot of the skills**. For example, before we wouldn't have to wear gloves to make up antibiotics ... So, in the labs now they are taught they **have to** clean out the kidney dish and wear gloves. So, there is a **big difference** than if they go out and they haven't bought that in yet. ... And then the staff are saying '**What are you doing?**', and then they say to the student 'You **have to do it this way! This** is how you have to do it.' And so the

students get very confused ... Some hospitals have bought that in and others **haven't**.

Understanding that rollouts of new DOH directives occurred over a long period had enabled Elly to make sense of why mismatches occurred between the timing of an HEP teaching its students and when changes to practice occurred in the health settings. Here the student felt threatened and was not invited by HSS to explain how new evidence for practice had emerged. As other nurses in the clinical area had not been exposed to the new expectations, the student was expected to adhere to current practices rather than best practice. This action did not allow the student to bridge between theory and practice.

Although there were various approaches to undertaking psychomotor tasks, student nurses were taught general principles to provide appropriate care for their patients. They were also exposed to a variety of health setting policies and new DOH policies. Student should be familiar with different health setting policies, guidelines and student scopes of practice during their training. However, students were threatened with failure by facilitators when they followed the practices of HSS that did not adhere to the general principles expected for safe nursing care or did not use policies of the HSP to guide their professional practice.

Ashley reported on a situation where she observed a student preparing medication unsafely at the reception desk, which was a public area:

preparing IV [intravenous] medication at the nurses' station ... so they're doing this work ... in a public area ... contravening what I thought was infection control standards, medication and administration standards, many standards ... I said, 'don't you let me catch you doing that'. They [students] know to mix it in the medication room. But we talked about the whys and wherefores and accreditation and standards, what governs this type of practice. And the student was working outside her scope and that's an example of working outside your scope ... I am responsible in this institute to the placement coordinator ... To tell her [the clinical manager] that students that she is assigning to that group, that they are not being properly supervised firstly and secondly that there was unsafe practice that seems to be accepted as the norm.

Here a lack of space had contributed to the conflict of safely preparing medications for patients. Ashley's expectation that the student should not follow the standard practice of the other nurses had placed the student in an uncomfortable position as HSS continued to prepare medications in this manner. The student was threatened with failure as Ashley tried to remain in control of the student's ability to practice safely.

In summary, students needed to demonstrate safe practice and adhere to the policies and guidelines that health settings had adopted for the provision of nursing care. This was expected as part of their scope of nursing practice. However, students were affected by the cultural practices of the health setting and were notified of the likelihood of failure if they did not practice as CFs expected. To manage, CFs had students recognise that students needed to take control of practising safely and the CF would hold them accountable for this even when HSS did not perform in the manner that was expected of a RN. Students were also expected to practice according to their scope of practice. These narratives suggested that strategies and processes and knowing with whom to discuss issues was essential when dealing with differences or mismatches between practices.

5.3.2.2.1.2 Identifying Mismatches in Nursing Charts

Students on a final placement had been tested in the academic setting and had prior experiences to demonstrate that they could recognise safe parameters when conducting patient assessments. However, as students rotated to various health settings and as new nursing documentation was implemented over time, it appeared that participants had noticed that students on a final placement still struggled when there was a mismatch between the tools and parameters to which the students had been exposed. Elly reported:

I set foot in so **many different** hospitals. There's just **too many different things** ... **The parameters are different to what they are learning at uni.** So, what is the [HSP#4] paperwork uni is different to the paper format at [HSP#2] ... So, it still looks the pretty colours, but the **parameters are all different.** I can only speak on [HEP#2's] behalf, but they can't ... cover **every different hospital's policy.** ... when you're teaching, you're sort of saying, 'Well, it might be different in a different place'.

A student on a final placement was unlikely to appreciate the nuanced differences between health setting tools and the parameters taught to them by their HEP. Elly empathised with the dilemma that this would create for HEPs as they could not cover all providers' assessment tools but could only teach general principles. Although Elly managed by explaining to the students that different settings used different parameters and policies, students may have been left feeling uncertain. Nonetheless, students would need to know how to use the health setting's tools and policies to demonstrate they were ready for professional practice.

Barbara found a very competent student who struggled to maintain safe practice because the charting system used in the health setting was new to the HSP. It appeared that the student had also not used as a backstop the assessment chart from the university at which they had trained. Barbara reported:

I had a final-semester student, who did a blood pressure ... and the new clinical deterioration chart had come out, the ADDS [Adult Deterioration Detection System] chart ... but she had written on the ADDS chart the low blood pressure, but she hadn't reported it to the registered nurse ... and I made an assumption, **wrongly or rightly**, that this would be something they, the charts they would have used in labs and things ... but there was a couple in the group that did not know **what** the actual chart was. So, I went through a session and explained that to them. So that, you know, is one area of safety.

The ADDS chart assisted HSS and students to know when to call in the emergency response team. Barbara and the HSS had assumed that the student was taught using the latest assessment tools. However, as the program conducted by the Australian Commission on Safety and Quality in Health Care (ACSQHC) in 2014 had trialled five versions of this assessment process (Elliott et al., 2014), the tool was new to the settings and varied between them. In this instance, the CFs and HEPs had not used a version of this tool to educate their students.

In current practice, HSPs could modify some of the ACSQHC tools to incorporate additional observations they deemed necessary for monitoring patients' progress (ACSQHC, 2010). Students were assessed as being at risk of failing their final placement when they used parameters taught by the HEP that differed from that of the HSP. However, given their academic training it was likely that students would expect

the parameters taught by the HEP were consistent with the parameters HSS would use to assess patients.

Through questioning the student, Barbara identified how their training had not been consistent with use of the health setting's assessment charts. She linked this possibility to other students, investigated the scope of the risk and took control by providing education sessions for her cohort of students. If participants were not aware of difference between providers' tools, it was unlikely that they were able to understand why students did not know how to use the assessment tool. If the CFs were aware, they were better able to help students navigate these differences by reminding both students and HSS that differences in resources did occur; monitoring for these differences; and increasing students' knowledge about the health setting's resources.

Participants highlighted their frustration when they received conflicting opinions about what students were allowed to do in health settings. Participants recounted examples when mismatches had occurred as HSS were not sure about students being able to give drugs that were identified as controlled or restricted medication. Debbie reflected:

It's the same with doing S8s and S4s. They're not allowed to do it anymore ... and that's another thing that I have to take up with the university clinical coordinator. She's **got to** sort it out with the hospitals because some of the hospitals, some of the staff in hospitals are saying 'Oh no, it's the unis that says you **can't** do it' but it's not. **It's the hospital policies** that are saying that the third years, or even, [correction] no student nurse, can give an S8 and **yet** on the thing that came out from the government, that says they **can't** be a second signer, but they can be a third signature, and they can administer it. I can't see where that sits [sounds confused].

Having mismatches in understanding of what students could practice created increased stress and anxiety for Debbie. To manage for this confusion, Debbie relied on the HEP's and HSP's clinical teams to provide clarification and communicate their expectations for a student's final scope of practice. As policies, guidelines and DOH standards change, clearer communication practices between providers about the student's current scope of practice appeared to be necessary. These changes might also have reduced previous opportunities to practice certain skills.

Participants also described how students on a final placement were denied opportunities to access certain areas within the CLE. This denial had occurred because the ‘opinion’ of staff had guided the behaviours of staff and students. Ida reflected:

Basically, students are allowed into the treatment room cause it contains more than drugs ... that opinion has pervaded the **entire** hospital and that was constantly what I got. You know, students being reported for doing that. And I’d say, ‘No! Students **are** allowed to go in there because they need to get the dressing pack’ ... so you can’t say, ‘You can’t go in there’, and then suddenly they’re registered, and they get to go into a place that they’re not allowed.

In this situation, opportunities were denied for students to independently collect and provide equipment for patient mobility. In using the cycle to I, A & M risk, Ida was unable to manage and provide opportunities unless the support of senior staff was available to replace ‘opinion’ with correct information. As participants relied upon the HSS to direct and provide information to them and students, participants appeared to have difficulty in modifying students’ past individual opinions about what they could practice. The differences among opinions would also have increased confusion about practice. The next element describes how participants managed a student’s scope of practice.

5.3.2.2.2 Managing the Student’s Scope of Practice

Most participants reported on a student’s nursing scope of practice as a way of assessing how safe a student was. HEPs provided all students with the specific skills related to tasks and job-related skills. Students could practice what they had been taught and examined upon by the HEP, and then authorised by the HEP to practise. Once students were on final placement, the HSP determined what the student could practice in their setting. Students who were experienced international nurses or ENs were only able to undertake skills taught by the HEP and as the health setting permitted.

Ida was asked, ‘What determines their final scope of practice?’ and she replied, ‘Well the theory that they’ve learnt and how much their understanding, their previous competencies that they’ve done. So, it depended on where they’ve worked’. Elly verbalised, ‘I had students in theatre who had an opportunity to remove airways in

recovery and so that was something that **wasn't allowed**. So, I checked with uni and they said definitely not'.

Debbie reported that the scope of the student's and RN's practice could differ. She stated:

a lot of them want to do male catheterisations, which they do in uni. They're not allowed to do them at [HSP#6] ... It **has to be** a self-directed learning package and they have to be assessed on it before they can actually do it ... It hinders them, because when they get out on their prac they can't do it.

Here Debbie was referring to the processes that an RN would follow to expand their learning through education and follow-up assessments of this skill. When Debbie was asked if students could 'actually go through the self-learning package', Debbie responded, 'No'. Students on a final placement did not have this opportunity to practice the skill they had been taught by the HEP or to expand on their current list of skills or scope of practice. Elly explained, 'You **still have** to have some **control of them** as they are **still** students, so I do understand. We have to have limits'. Barbara reminded students that they needed to be mindful that RNs also needed to stay within their scope of practice. She reported:

When you graduate, it doesn't mean you can do everything and anything ... You still have to have competencies There are still things you aren't going to be able to do ... I say to them, 'Go and ask the other nurses what they ... can and can't do'.

HSPs had clear protocols and policies about students working within their setting. These protocols were to protect staff and students. Ida verbalised, 'I think that the final-semester year **didn't always see** that the hospital had protocols and processes to protect staff and themselves from **the students**'. This narrative indicated that protocols and policies for students would protect individuals.

In summary, the participants expected students would practice within the scope of practice that the HEP had outlined for them. Although opportunities arose for them in the setting to undertake specific skills taught to them by the HEP, HSPs did not permit students to undertake practice. This increased the likelihood that students would be denied opportunities to perform specific skills, but would allow training and service providers to remain in control of what skills students used.

In summary, this theme ‘Being stuck in traffic: Navigating past the obstacles’ has outlined how participants noticed the effect of shifts, infrequent and short placements, mismatches in the use of resources and the use of best evidence on student competency and capability. Participants identified that differences in psychomotor skills affected a student’s confidence and their sense of belongingness. The mismatches in the use of resources increased confusion about how to practice and students appeared ‘caught’ between psychomotor skills expected from individual nurses, their training, the CF, the DOH and the policies of the HSPs. Having a background of academia and being flexible in the management of these issues appeared to be the most effective way to overcome the risks to students’ progression. However, participants were not always able to steer past the obstacles related to resources.

5.4 Chapter Summary

Phase 1 is titled ‘Navigating current traffic conditions’ and has two major themes’ ‘Having greenlights: Enabling the journey’ and ‘Being stuck in traffic: Navigating past the obstacles’. The research findings described and interpreted how participants had identified, assessed and managed enabling and hindering factors related to the contexts, people and resources. They managed with a variety of approaches, values and tools to develop relationships with ‘co-drivers’ to obtain feedback and drive learning. They had learnt to weigh up the feedback they had received and had assessed that the likelihood of risk was increased when the scope for changing relationships and resources were outside participants’ control. The next chapter outlines the final two major phases of the framework.

Chapter 6: Forging Ahead and Reaching the Destination

6.1 Introduction

The previous chapter described and interpreted the first and second themes of Phase 1—Navigating current traffic conditions. The first theme was titled ‘Having greenlights: Enabling the journey’. The second theme was titled ‘Being stuck in traffic: Navigating past the obstacles’. The theme described and interpreted how participants had responded to the enabling and hindering factors related to people resources and to the current conditions for which they must negotiate. Although the risks were not quantified, the likelihood of risk was evident in how participants were able to I, A & M these risks.

This chapter continues with the final two themes of the STR framework: Phase 2—Forging ahead and Phase 3—Reaching the destination. Phase 2 findings describe and interpret how the participants had forged ahead with identifying, assessing and managing students. The findings of Phase 3 describe how participants had determined that students had fulfilled the requirements for eligibility to register practice. It concludes with the experiences of participants making recommendations to pass or fail students (see Figure 91).

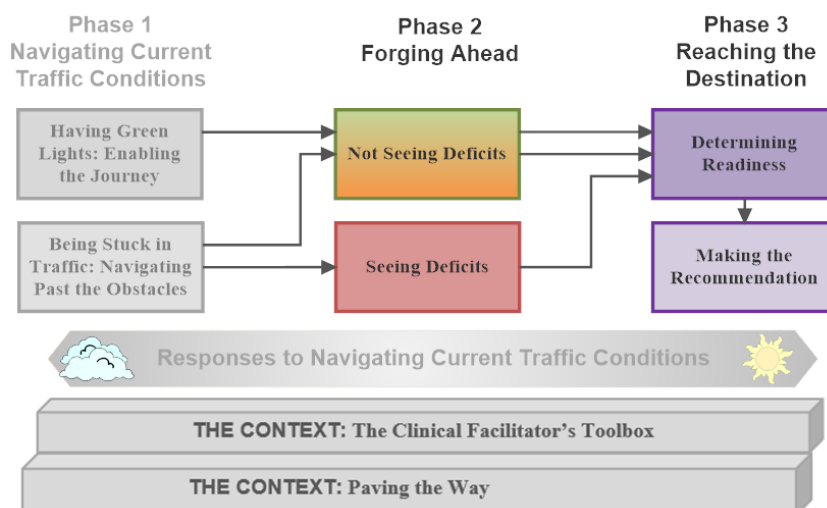


Figure 91: Phase 2 and 3 of the Steering Towards Readiness framework

6.2 Phase 2—Forging Ahead

Phase 2—Forging ahead is the second phase of the STR framework. This phase illustrates how participants perceived nurses and how CFs did or did not see deficits in students’ provision of nursing care. To clarify learning deficits, participants used focussed assessments and when needed gave struggling students a LDP. This plan assisted students to identify, assess, plan and obtain learning opportunities to make up the shortfall in their knowledge and practice. Elly reported:

With this theme the driver, I find it’s really important to **set goals** for the students and **encourage** them to set their goals ... So, at the start of every shift you have to have a small goal: ‘What do you want to achieve?’. And I think they **need** someone like a clinical facilitator to, to **make** them do that ... really **driving** them to achieve something.

This phase is illustrated in Figure 92.

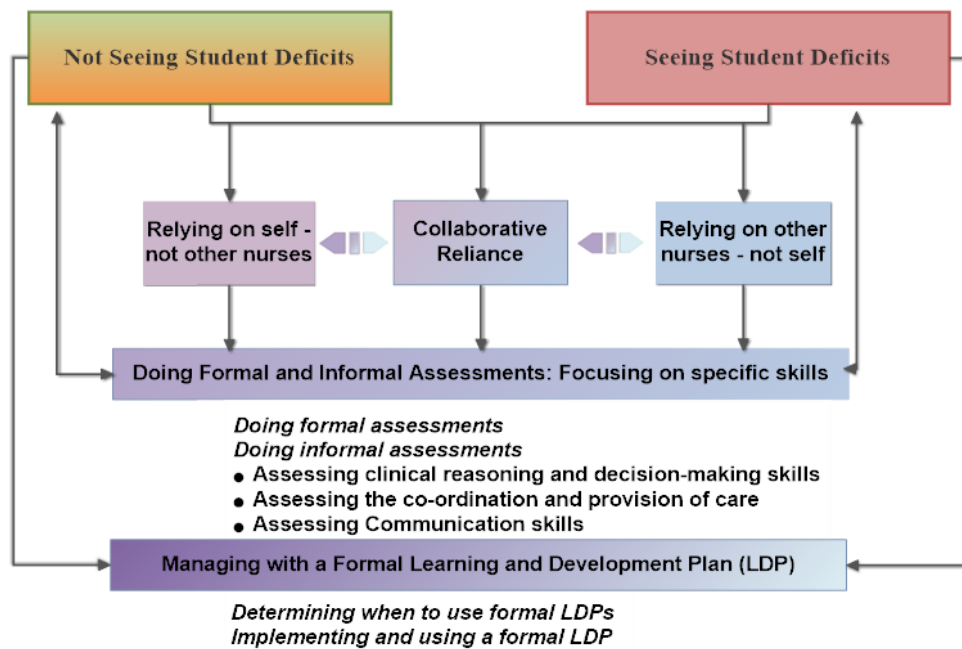


Figure 92: Phase 2—Forging ahead

This part of the participants’ journey shows how participants did or did not see deficits in student practice when they were reliant on other nurses and students (blue sections), on themselves (purple sections) or in cooperation with other nurses (blue and purple sections) to I, A & M risks to student practices. The segmented arrows illustrate the move towards or away from collaborative reliance to I, A & M risk. The colours of

the sub-themes, ‘Doing formal and informal assessments’ and ‘Managing with a formal learning and development plan’, intensify for participants as they take more responsibility for assessing or managing risks to student readiness. The first theme is titled ‘Not seeing student deficits’.

6.2.1 Not Seeing Student Deficits

In this section, the participants’ narratives describe how deficits in student nursing practice were not seen as participants relied on themselves, on others or in a collaborative approach for assessing students. Not seeing the deficits was related to the context of facilitation, workplace demands and seeing the learning needs of students. In the example provided below, the deficits in a student’s readiness to practice were seen by the supervising nurse but were not seen by the participant. Ashley stated:

The ward was busy or something and the student had been going through the patient’s notes trying to understand the patient’s [pause] trip through the healthcare system. So, the student was doing what she wanted to be out on prac for. She **wanted to understand the diagnostic process** and the trip through the system, blood labs and everything else ... [to] meet her learning needs. But the RN had flatly said the student was lazy ... But she is going to be a wonderful registered nurse, **somebody I wouldn’t mind waking up** to, one day. She will understand my care ... And that’s part of, I think, the team nursing effect, the task orientated.

This theme outlines concepts pertaining to the inclusion or exclusion of relying on other nurses’ inputs. As the concepts were found in both ‘Not seeing student deficits’ and ‘Seeing student deficits’, the sub-themes are titled with the prefixes of ‘Not seeing deficits’ and ‘Seeing deficits’ The segmented arrows in Figure 93 illustrate the move towards or away from collaborative reliance to I, A & M risk. The factors that enable this move are now described.

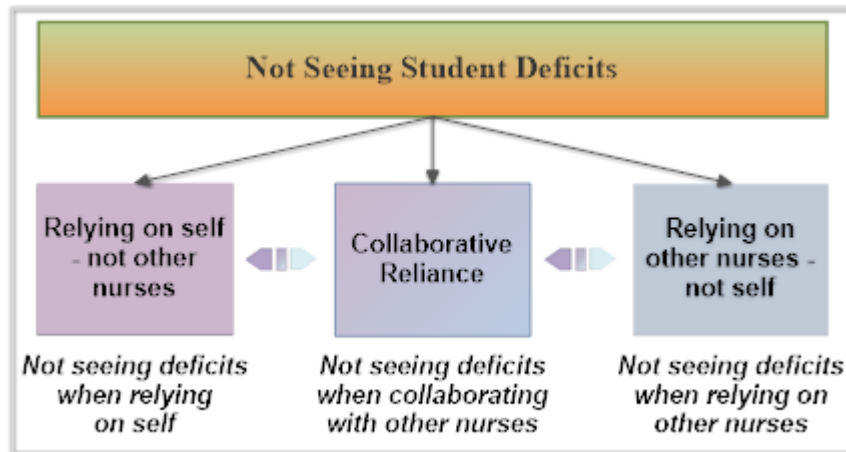


Figure 93: Not seeing student deficits

6.2.1.1 Not Seeing Deficits When Relying on Self

Not seeing deficits when relying on self was related to contextual factors such as the inexperience of the facilitator, the personal characteristics of CFs or a lack of assessment. Although participants expected to rely more on themselves to see the deficits, they described how there were gaps in how they or other CFs assessed students. Elly stated, ‘I think its [pause] just **experience**, when I started ... I honestly **didn’t know** what I was having to assess. I didn’t, **there was no rule book** on you should be assessing this’.

Ashley commented on others who did not value the assessment process:

If you get a facilitator who doesn’t do that [Questioning students about their reflections] and just ticks off yes the student is achieving ... she has written a reflection; she thinks she went okay ... walks in, walks out and, and, if she doesn’t sit and question the student, **she** [the CF] **doesn’t learn** that she [the student] understands the domains.

These narratives indicated that the quality of the assessment process was influenced by the values, education and experience of CFs. Relying on self where there was a lack of attention to the assessment process resulted in an ineffective assessment. The next sub-theme describes how participants did not see deficits when they had relied on other nurses.

6.2.1.2 *Not Seeing Deficits When Relying on Other Nurses*

Participants reported that HSS sometimes did not see the deficits in the student's nursing practice. This led to gaps in the assessment process they had used. Gaps appeared to occur in other nurses' assessments because of the demands of the workplace and a lack of awareness or concern for the assessment of students.

Elly indicated CFs might miss seeing deficits relying solely on other nurses. She stated, 'You could **easily** pass a student that **wasn't competent** by the fact if you just went in and just took the preceptor's feedback as the only assessment that you did'.

Gaps in the assessment process of other nurses had also occurred because responsibility for assessment was not taken. Barbara said, 'Nurses these days don't almost, don't assume the responsibility of being an educator for other students. They **don't** have time'. She also indicated that not taking responsibility was a result of the high workload of nurses.

Ashley was another participant who appeared troubled as she reported on other nurses' lack of attention to students' learning objectives. She stated, 'I will ask students "does your preceptor ask you ... **What stage it is? And what do you want to get out of today?** ... what I can I help you learn today?"'. When asked, 'And what do they say?', Ashley replied, '**Nobody!** I need to be talking to the student about does she understand the medications; does she understand what's going on ... **Not many of them do that**'. This narrative indicated that other nurses were not accepting the responsibility for assessing students. This indicated potential problems with CFs relying solely on nurses to identify and assess student progression because the feedback CFs received may not have been an accurate reflection of a student's progression.

These scenarios indicated that when other nurses supervising students were too busy to identify or assess student progress, CFs would not see deficits. As some participants previously reported they only had 1 hour a week to support students; thus, the lack of quality feedback from other nurses was likely to influence how effectively the CF would be able to I, A & M risks. Further to this finding, when deficits were reported by other nurses in a collaborative relationship, the participants did not always see that there were deficits in the students' progression.

6.2.1.3 Not Seeing Deficits When Collaborating With Other Nurses

Participants also indicated that deficits were not seen by them or by other nurses when collaboration did occur. Further, deficits were not seen by them or by other nurses when collaboration did occur, which was related to differing expectations for final placement students, the model of patient care and disagreeing about perceived deficiencies. In these narratives, participants viewed the assessments of students differently to other nurses.

Fiona described how she collected information from other nurses, but this was obtained during a formal group meeting:

Then at this **last big meeting**, there was myself, my clinical practice manager, the clinical nurse manageress of the ward and the HR [human resources] person ... the clinical practice manageress ... **Well, they didn't have any evidence.** There was **no** evidence whatsoever ... I **thought** that this is all **very, very strange** because they might not be happy with him as a person, but there is **certainly nothing wrong** with his **nursing** ... **I had** him as a student **for 2 years** and in class, he was **always** asking questions and listening ... **very self-motivated, and** he **really** took his learning process quite seriously ... I said, 'Yeah, I well am aware of all that, but what has he **actually done wrong**'. And it was basically the timekeeping ... missed a day or two because of family illness, but he made them up on the weekend.

It appeared that Fiona's history with the student in a previous placement had increased her doubts about other nurses' assessments of the student's practice. Fiona's narrative indicated that this student's time keeping was not related to providing patient care in a timely manner but was related to external factors. The student appeared responsible for both his family needs and his requirement to meet the expected hours.

Caroline also identified there were situations where in a group meeting, she had disagreed with HSS about how competent the student was. She reported,

But anyway, the other one [CS] really **still had it in** for her ... saying that she **wasn't competent** ... there was a meeting called because they felt there was issues ... I said to her ... 'Sarah [the student], I want you to write **everything** in a notebook, because of what happened day 1, day 2, like from the beginning. **And what they have made you do**, you know, like not being supervised' ... And Sarah

... walked in and saw all these people and I said, '**Don't worry, don't worry. I am here to support you**' We just fight!

This meeting appeared to have been called by HSS, which indicated the significance of the meeting. Having evidence was likely to provide Caroline with a way to address the issues that arose with the student. Her mode of engaging was to foresee future possibilities and encourage the student to defend herself. Caroline continued to say that the issues the student had experienced were related to workplace attributes:

So anyway, I said to the staff development nurse '**So what are the issues?**' ... she did not think my student came up to scratch in her skills. So, I said, 'Well, look, I would like to share with you what's happened every day with Sarah in the ward'. [Small laugh] ... It left the clinical nurse specialist gulping, '**Oh**' she says, '**we have a problem here**' ... So anyway, the meeting ended and we came out smelling like roses and they realised they had a problem.

It appeared that senior nurses could be unaware of issues that supervising nurses (CSs or preceptors) may have had when supervising students. In this narrative, the CN specialist was able to see that the deficits were not related to a lack of competence, but to workplace relationships and culture. The amount of energy expended to solve this conflict appeared to increase the level of stress experienced by other nurses, the participant and the student.

As participants encountered these types of issues, they were more likely to weigh up the relationships, the quality of the assessment and their responsibility to act justly and provide a fair assessment of the student's ability to be ready for the role of the RN. Gemma said:

I made my own decision; I didn't take on board the staff development nurse because she was **just a once-off thing**. I had spoken to a few of the other nurses ... The time I had spent with her **just didn't make sense**. It didn't click. So, I thought You know what, **I'm not taking this on board, and** I will make my own judgement. **I didn't say anything** to the student, **didn't bring anything up**.

In this situation, Gemma did not accept the reported deficits as the SDN had not worked with or managed this student before. This was a significant factor to consider, as this feedback was incongruent with what she had observed. Gemma made a clear

distinction about turning away from this feedback to relying on her assessments, and turning towards other nurses to seek out further information about the deficits.

In summary, this theme of ‘Not seeing student deficits’ is described as one of collaboration as well as one of relying on themselves or others to identify deficits. Participants relied on feedback from HSS, weighed up feedback considering the assessments or contextual conditions and disputed feedback when it was considered unfair. Participants needed to unravel the differences in perception when HSS noted deficits during students’ nursing care and when participants had not observed these deficits themselves. These meetings indicated that clarifying deficits could be stressful for some individuals; similarly, when CFs noticed deficits and HSS had not noticed them. Participants tended to rely on the assessments they had made of students.

6.2.2 Seeing Student Deficits

Participants were also able to see the deficits in students’ practice when they had assessed students, when they had relied on other nurses and when they collaborated with HSS and feedback to students. Harry stated, ‘You’d tend to see it coming if there is problems or they’re having some kind of distress’. Debbie reflected:

So, if they [the HSS] tell me that the student’s not doing what they should be doing, [participant tapping the table] I then question the student about what has happened. Because I know that there’s a lot of conflict, with personality conflicts ... So, **you’ve gotta** see two sides of that. And then I would go and work with the student. Just to see what they’re saying to me is true.

The first three sub-themes for seeing student deficits are illustrated in Figure 94: ‘Seeing deficits when relying on self’, ‘Seeing deficits when relying on other nurses’ and ‘Seeing deficits when collaborating with other nurses’.

The solid purple arrow indicates that CF participants took control of giving feedback to students from other nurses as other nurses did not always give students necessary feedback to help with their development and progression. The first sub-theme for seeing student deficits is ‘Seeing deficits when relying on self’.

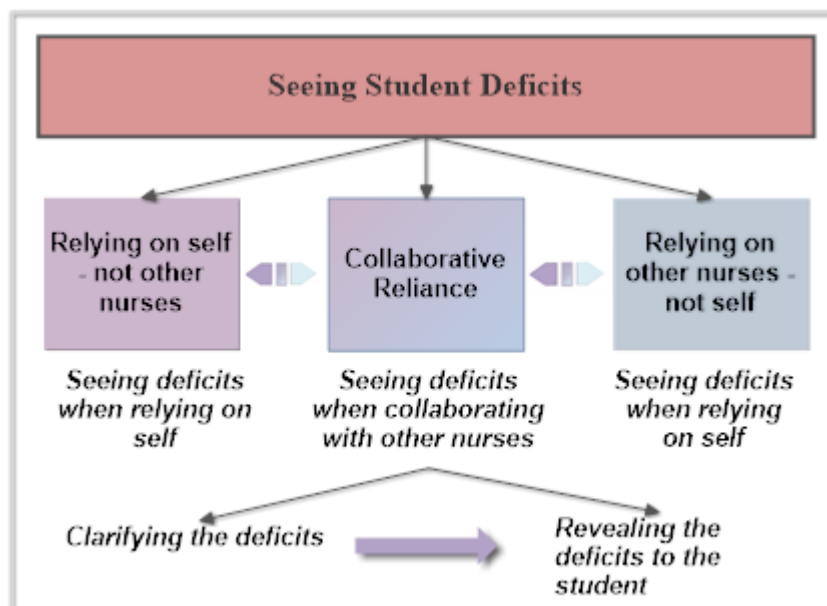


Figure 94: Seeing student deficits

6.2.2.1 Seeing Deficits When Relying on Self

Seeing deficits was related to observing students and their interactions with others; in particular, participants shared their past experiences of managing international students who struggled. Gemma explained how she spent time with her students to identify risk. She stated:

I **usually do** in the first couple of days I spend a lot of time working with them just to get that **feel** ... So one of the things I've picked up, because I have been doing this job for a while is **always by the end** of the week, by end of Thursday or even after Wednesday, if there is something really going on you can get to know your students by spending 2 or 3 days with them and **you kind of know** what path they're on.

Caroline reported she could tell by observing the students' interactions. She reported:

You go up there and although they are buddied, you ... watch them working, or watch them communicating with the patients and all that sort of thing. **You can tell.** It doesn't take very long to know if you've got somebody that's very good or not. You know.

Noticing risk was referred to as an intuitive response. In practice, it seemed that the observation of students would reveal the deficits in their practices. Elly picked up on

deficits earlier as she had experienced the need to rely on herself and had noticed that international students struggled:

So, preceptors don't have the time to do that, so **I will** ... At **all** stages along the way, we need to be assessing what the student's information that they're gathering ... Because I have had a lot to do with the international students in the past, so I tend to jump on that a lot earlier than most.

This meant that she could not rely heavily on other nurses for assessing how students were developing and needed to be more responsible for making the assessments herself. As she took on the responsibility for identifying, assessing and managing the risks to readiness, her mode of engaging shifted from relying on others to relying more on herself. Seeing deficits was also found when participants relied on others to see deficits.

6.2.2.2 Seeing Deficits When Relying on Other Nurses

Participants sought feedback from other nurses and could then see student deficits. In some instances, participants relied on HSS to see deficits when students were in specialty areas such as a theatre and when the model of facilitation dictated their interaction with students that limited opportunities to see deficits in student practices. As an experienced theatre nurse Caroline said:

[I] **really didn't** have to do anything except meet the students and do their paperwork because they really didn't want another person in there in the theatre ... Well, I just had to rely on the staff development nurses.

As an inexperienced CF, Elly also described how she relied on HSS when her student was on a theatre placement:

I would have **been totally uncomfortable** to assess the students ... I did rely heavily on the staff development nurse to fill out the form because she was the one who was **assessing the students really**. So, I was just there if anything was needed from my point of view. But it was **really her decision**.

Both Caroline and Elly were able to let go of their need to control. By relying on other nurses, they had been able to within 'arms reach' determine the students' assessments

and had been successful in ‘a quest for shared community values’ (Figure 20, HTMETS #13). The shared view was that of identifying and assessing practice.

In summary, the participants’ mode of engagement with others was one of reliance. They could see these deficits through the eyes of HSS, which in turn was influenced by the HSP’s expectations for facilitation, the background experience of the facilitator and the processes used for facilitation. These factors could take away participants’ control of the identification or assessment process. These narratives also indicated that other nurses were more likely to manage deficits. However, more control of identifying and assessing deficits occurred when the participants had collaborated with other nurses to identify and assess students’ progression.

6.2.2.3 Seeing Deficits When Collaborating With Other Nurses

Although participants expected to rely more on themselves to see the deficits, they described how there were gaps in how they or other CFs assessed students. Participants were accountable for clarifying the deficits and providing this information back to students. The elements are titled ‘Clarifying the deficits’ and ‘Revealing the deficits to the student’.

6.2.2.3.1 Clarifying the Deficits

This theme describes how participants clarified what deficits they or other nurses had seen. The giving and receiving of feedback appeared essential to understanding the deficits they saw. Elly described how she had seen the deficits with other nurses:

Personally, I do listen to the feedback from preceptors, but **whatever I hear** from the preceptors I still want to assess for myself ... The universities **have** their skills that the students need to be **signed off on**, but if I **only relied** on the preceptor's feedback, I think a lot of students will get through that **shouldn't** get through ... There is a lot of staff having trouble disassociating with not marking someone on their personality ... So, I focus on the things that I know the preceptors aren't looking at and then once I have done my assessment, then I will go back to the preceptor and say, ‘Look, has this happened?’ ... If **someone** feedbacks that they're not ready I will do my own assessment and ... clarify what their thoughts are You take everyone's opinion of why they think they're not ready.

Elly indicated that she valued the assessment and feedback of other nurses and deliberately tried to fill the gaps in other nurses' assessments. Unravelling perceptions related to personality or other contextual factors appeared to be central to sorting out whether deficits had occurred. Participants reported they would conduct their own assessments. Barbara stated:

I did it for patients really, [laugh] cause if I assessed the student as **unsafe** and everyone else said the student was safe, I wasn't going to **let it go**. However, if someone else said the student was unsafe and I thought they were safe, then I would have to revisit **what made them safe!**

Her mode of existing was authentic as she took ownership of the assessment and re-assessed the student.

Ashley provided an example of how other nurses 'loved' one of her students and had missed seeing the deficits in the student's practice. She recounted:

I think of an example where I had said to one of the students who had told me that her patient had a fractured neck of femur, she **couldn't tell** me where the femur was. **She had no idea** ... Some basic, some **very basic** knowledge deficits. **The patients loved her and so did the staff**. Because she got in and **did stuff**, but she **didn't know** what she was doing. The preceptors reported a student who is motivated, yeah, she's helpful, **she does this and she does this**, but when I spoke to her, she had **no clue** what she was doing. And that is quite common.

Ashley demonstrated that she was proactive in being the gatekeeper of safe practice. The discrepancies or conflicts in assessments were likely to increase her level of concern and her need to rely on herself to see the deficits. When deficits were seen by other nurses and had not been disclosed to the student, some participants would reveal this feedback to students.

6.2.2.3.2 Revealing the Deficits to the Student

Participants highlighted that when other nurses had made them aware of perceived deficits, they would relay this assessment back to students. They wanted to ascertain how much the student was aware of the reported deficits and to clarify any issues students had. Ida reported on the need to share how HSS perceived the student was

progressing. She said, ‘And then ... coming back to the student and talking about the situation and sometimes it was a case of me having to share **how** other people saw the issue with the student’.

Barbara shared her process in having this conversation:

If at any stage I feel that there is any risk ... where the patient is not safe, then we need to have a conversation ... So usually, if something comes up, I have a conversation with the student. The student has an opportunity to rectify or address the problem. If **they don't know** there is a problem and **I do**, I'll often sit down with them and have a conversation with them and then I will give bit of a **feedback and** then I'll say ‘Look, are you aware that there's been a problem with x, y and z?’. And sometimes they'll say, ‘Yes I do, I thought that might come up’. Or they will say ‘I don't know what you're talking about’.

If a student was unaware of these deficits, it was likely that the HSS had not given them this information.

Caroline indicated that when she needed to deliver negative feedback about a student's clinical practice it was bracketed by aspects of positive feedback. She stated, ‘You **always** hit them with the positive first before you hit them with the negative. It's much better really, cause, you could **finish off with something positive as well**’.

These actions indicated that the participants' concern for students was one of safety and of wanting to move students forward. These participants sought to make students aware of how they were perceived by HSS, including their deficits, noting that not all participants agreed with the deficits reported by HSS. As participants took on the necessary role of providing HSS feedback, they considered how the student would react to this information.

Two further sub-themes of ‘Seeing student deficits’ explain how participants were able to I, A & M deficits. These concepts are titled ‘Doing formal and informal assessments: Focussing on specific skills’ and ‘Managing with a formal LDP’.

6.2.2.4 Doing Formal and Informal Assessments: Focussing on Specific Skills

The findings indicated that both CFs and other nurses would undertake formal and informal assessments. When undertaking informal and formal assessments, the

participants identified that they had focussed on specific skills. Participants appeared to value their independent assessments about a student’s ability to practice. Barbara said:

I know as a driver, I make my own assessments. I **don’t** always just rely on someone else. **In fact**, I might do my own assessment and I might query what others have written. I don’t always take that at face value. I will **always do** my **own** independent assessments.

The two concepts of ‘Doing formal and informal assessments: Focussing on specific skills’ are titled ‘Doing formal assessments’ and ‘Doing informal assessments’. Figure 95 shows the focus and interpretation of how the assessment of clinical skills occurred. These are titled ‘Assessing clinical reasoning and decision-making skills’, ‘Assessing the coordination and provision of care’ and ‘Assessing communication skills’.

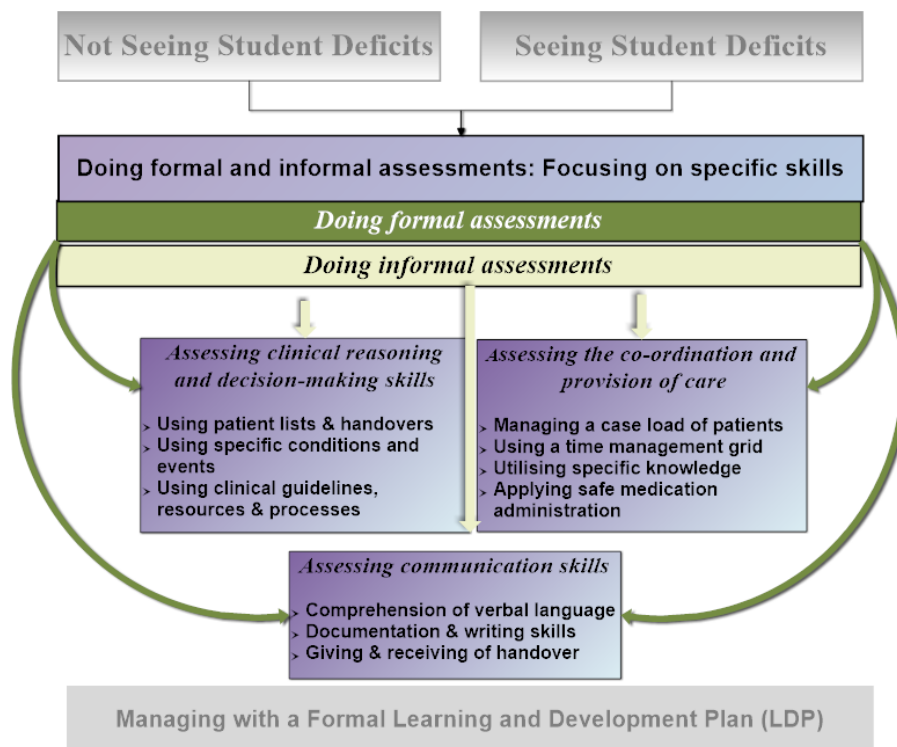


Figure 95: Doing formal and informal assessments—focussing on specific skills

The purple and blue colouring in Figure 95 indicates that participants would to varying levels rely on themselves, on others or on collaborations with others to assess students and identify deficits. The light and dark arrows show that formal and informal assessments assessed similar aspects of the clinical competency of students. However,

informal assessments occurred throughout the whole period rather than at a midway or at the conclusion of the practice period. The narratives reveal the specific skills participants wanted to focus on to ascertain risk. The participants' understanding of undertaking formal and informal assessments is now described.

6.2.2.4.1 Doing Formal Assessments

Participants described how formal assessments were performed on students by both participants and HSS. It appeared that HEPs expected participants to conduct formal assessments on specific nursing skills at the halfway mark and at the end of the placement. These assessments would formalise the grade of the students and identify if students were meeting the expectations for independent practice.

Harry reported that he would go through the student's NCAS at the end of the placement. He reported, 'So it's, it's, as facilitators we sign off the **final document**, but I go through the document'. Debbie reported how she not only read the students' NCAS as part of the formal assessment process but also explored the reflections with the students to ensure that they mirrored current experiences. She reported:

And I know a lot of facilitators collect their books and take them away to read them. I don't. I sit there with them and go through and ask questions about what they've actually written and say, 'Oh what did you do there?'. So, I know what they've written is what they've actually done. It is not something that they've done two pracs ago and thought that 'Oh yeah, I will write this down for this particular element'.

Debbie reported that she undertook formal assessments on her students midway, during and at the end of the placement. She revealed how specific skills would be assessed:

Well, they've got this new thing where they've gotta write when you do an assessment on them and they've gotta write a reflection on what they, how they felt their, their assessment went ... halfway and one at the end. And their reflections have to incorporate the domains ... we have to actually go in and do their assessment on their medication and all these other dressings and all this other stuff. There's five, I think ... **Where before**, I would just wonder around and just peek in and see how they were going, but just leave it up to the preceptors to do stuff.

Caroline also stated how many specific skills she would assess students on when they were on their final practicum: ‘They had seven to do; you know like teaching (yes) teaching a colleague’. Elly reported she was expected to formally assess the ability of the student to communicate when students used ESL. She stated, ‘So, with the uni that I work at, we do have the rubric for communication. So, it covers areas of speech, listening, reading ... That is done at the halfway mark and at the end’. Although formal assessments were expected to cover specific skills, participants revealed they would informally assess student practice.

6.2.2.4.2 Doing Informal Assessments

Informal assessments were done to ascertain or clarify where deficits were occurring in the student’s practice. Participants chose how they would or would not informally assess specific skills of students. Elly reported that she would not only do formal assessments on communication skills but indicated that when students were from a NESB, she would undertake informal assessments throughout the practice period:

I tend to do it more than just at the halfway mark and at the final mark so that I can **identify things earlier**. But that’s, I think my experience because **I have** had a lot to do with the international students in the past, so I tend to jump on that a lot **earlier** than most.

The need to act earlier was essential as CFs had a limited amount of time to I, A & M risk to student readiness.

Barbara also described when she would work with a student: ‘**I will go and work** with the student ... I go and see the skills [pause] I just pop in, **not to be difficult** or to be surprising but to **just see** how the students are communicating’. Ashley reported that, ‘If I happen to walk onto the ward and they’re about to do a dressing or perform a clinical skill I’ll go and watch’.

Debbie reported on performing focussed assessments when students were reported as struggling: ‘Well I **rely on** what the preceptors tell me and when there is a problem with the student. Well, **that’s when I go in** and I’ll do one-on-one stuff’. Debbie appeared to value preceptors’ input, but feedback about an unsafe or struggling student meant that Debbie would investigate further. Participants clarified how they would

assess specific skills in an informal manner. These elements consisted of ‘Assessing clinical reasoning and decision-making skills’, the ‘Assessing the coordination and provision of care’ and ‘Assessing communication skills’.

6.2.2.4.2.1 Assessing Clinical Reasoning and Decision-making Skills

Participants relied on themselves to assess clinical reasoning and decision-making skills and described how they used patient lists and handovers, specific conditions and events, as well as clinical guidelines, resources and processes to test students’ understanding. These were skills necessary for students to demonstrate their ability to critically reflect on how they applied their knowledge when they provided nursing care.

Barbara reported on wanting to see her students think critically about the care that was needed:

I am **more** interested in their critical thinking and their analysis of what they are doing than clinical skills. So, I’ll often go to handover. I will come back an hour later and I will sit down with the student and I will get them to tell me **all** about their patient; what their **plan** is and who are they are going to go to. Like **who else** is involved in their care, what are you going to do about this?

Debbie identified struggling students by exploring the clinical reasons why the student nurse would take certain actions when providing nursing care. She reported:

Sometimes I get them to talk about a patient and that’s what I was doing with him. I said to him ‘I’m going to pick one of your patients; you’re going to tell me everything you know about that patient, what you did for them and why you did it for them’.

Elly focussed on specific conditions and how a student might manage their patient’s care. She assessed how students reflected on managing a deteriorating patient:

Same as **MET** [medical emergency team] calls. **What would** you do if they [the patient] **met** the MET calling criteria? ... I would give them a little scenario and say if **this** was the patient’s observations, what would you do? ... I **always want to know** about students is what their understanding is ... conditions that no matter where you work you would be dealing with ... I ... give them a scenario and say

‘**what would** you do?’ ... So, if I wasn’t here and the shift coordinator was **busy**, well **how are you** going to manage when you’re on the floor and you are the grad? ... So how are you going to go about finding out? ... **I need to get them to show** me the policies. So, I do a lot of stepping back ... I’ve learnt that you **can’t just say** to a student, ‘Have you looked at the policy?’.

These narratives indicated that participants wanted to assess for themselves the student’s ability to critically think and reflect on what care was needed and to reflect on the steps they would need to take to manage problems that arose during the coordination and provision of care.

6.2.2.4.2.2 Assessing the Coordination and Provision of Care

Some participants reported how they assessed the opportunity of student nurses to coordinate and provide care to a group of individuals. Although the student’s care would be directly or indirectly supervised by other nurses, the intent was for students to lead that care. Barbara provided a clear outline of her expectations for students in a final placement and relied on herself to test student knowledge:

I usually alert them ... I will tell them upfront that sometimes it **is difficult to obtain** a patient load, which is very often one of their objectives ... they **ALL have to have** a **full load** for that ward ... If they are in ED [emergency department], I don't expect them to have six patients, but if they are in a ward, I expect them to take **full responsibility** and **they are** telling **their** nurse what they're doing and what they want and asking their nurse to help them. They're **not** having their nurse the other way around. So, the nurse is following them and is there to support them in doing that ... Something I ask them to get onto on the first day is an address book so that I can get them to put in all their acronyms and all their drugs in that ... **Yeah**, yeah, yeah. And we have a bit of a game with it and play and I will ask them you know, so what's this for ... It's **fun**. And I have a folder where on day 1 do this and on day 3 I do this, day 5 I do this.

Debbie reported that a student could struggle if they were not skilled in managing their time:

If ... they haven’t got their time management up to scratch ... they could be running the whole shift trying to catch up and feeling as though they haven’t achieved what they should have achieved for the day ... When they do their medications, they will

get their preceptor in to supervise ... **I don't go in** and work on a one to one ...
preceptors and buddies **don't like it**.

This action indicated that Debbie relied on herself to check that students had completed the tasks on the time management grid, but she had relied on other nurses to assess students on how they delivered nursing care.

Ashley appeared to rely on herself to assess the students informally on their ability to outline their learning needs and take opportunities to perform specific nursing skills:

I will ask them to, either confront the preceptor and say, 'This is what I need to do today. I need to care for this patient with a chest drain; I need to do that dressing, I want to go over to other side of the ward and watch the removal of that pic line or whatever'. To be assertive, to meet their own learning needs ... I will usually work with the student for a little while. I will **observe** ... giving out all the medication.

The next informal assessment describes how communication assessments were conducted.

6.2.2.4.2.3 Assessing Communication Skills

Some participants assessed how students on a final placement communicated and relayed essential pieces of information to professionals and patients. Communication involved the hearing, interpretation and relaying of information and the effectiveness of the student's use of written English. Students were expected to be accountable for relaying and recording correctly.

Harry was asked, 'Can you tell me how easy or difficult it is to assess their communication?', to which he responded, 'It is almost impossible'. He reported, 'It is down to the RN that's supervising them and then the SDNs that are looking after the unit'. In his liaison role, Harry left the assessment of language to other nurses.

In contrast to Harry, Elly strongly outlined the significance of personally assessing her student's use and comprehension of English:

Because of the language they [students] couldn't **understand** all of the other things as well ... that was **holding** them **back** from having you know, a higher enough understanding of how to manage ... So, I do feel it, that it **is important for me** to

do my own assessment ... I also observe how they communicate with the patients. So, I can tell, just by watching how they'd interact, and you can quite quickly pick up if ... the student doesn't understand what the patient is saying and like, you know, vice versa ... Sometimes they're **very honest** ... but other times they can say 'Oh no there's no problems. I'm great with this'. And then when you assess them you find out there is a **big gap**.

When Debbie was asked, 'Do you have a tool to assess language?' she stated, 'No! No! It's just listening I suppose and whether I can understand [nervous laugh]. You know **if I have trouble**, I know that the ward are going to have trouble'.

Gemma recounted how she could identify when students themselves recognised they were struggling with their English skills and how they tried to improve their comprehension:

I had one student whose English was **not her first language and** she used to walk around with a little **dictionary** in her pocket and would **open it up every time** she couldn't understand, which was **great** cause she was **trying**.

Participants not only assessed the opportunities for students to receive or give handovers but assessed a student's ability to communicate using technology and confidently comprehend abbreviations. Barbara reported:

I could tell **straight away** if they had communication issues. Not just when I talk about communication, I am not **just** talking about verbal communication I'm talking listening skills, ability to document, I can tell by their notes ... receiving handover for their patients, phoning doctors, paging doctors, they do it **all** ... and **also** ... they have to all go around and answer the telephone by the end of the shift ... They have to tell me all the acronyms on the handover sheet. That's actually one thing I notice that a lot of them don't know ... They **give** handover to me **before** they give handover to anybody else.

As acronyms and abbreviations were frequently used in nursing scenarios to facilitate communication, these participants expected students to learn, comprehend and articulate their meaning and significance. Barbara took action to ascertain any deficits a student may have in their ability to communicate with patients and other health professionals.

In summary, participants reported they had conducted formal and informal assessments to identify and assess deficits in specific skills. Although participants had performed these assessments, they recognised that students were not always assessed by other nurses and they had attempted to complete the gaps in student assessments. Some participants considered that processes to assess comprehension of the English language could be difficult. When students were seen to have deficits, the participants reported that a LDP could be used.

6.2.2.5 Managing With a Formal Learning and Development Plan

A formal LDP was a document developed to meet the individual student's learning needs. In a final placement, if the student could demonstrate they met the LDP objectives, they were usually recognised as being ready to practice. Barbara stated:

I think we look at it and think it's punitive, it's bad and just because we have an error it's a deficit. Well, **it's not** really a deficit; it's **just** an area that we struggle with. It's an area that we are **not** learning easily ... I think you can use it as a facilitator, but some of the facilitators will use it as a punitive tool ... It comes back to transparency **again** and looking at a formal LDP or contract ... and really, it's in the **student's** toolbox. **Not** the facilitators. It's **actually** the student's.

Participants used two strategies when managing with a formal LDP: 'Determining when to use a formal LDP' and 'Implementing and using a formal LDP'. Figure 96 illustrates these strategies.

The findings indicated that both CFs and other nurses could manage students with a formal LDP. Reliance on self or others or in collaboration with others is shown by the purple and blue colouring. The intensity of the purple colouring is shown to illustrate that a majority of the managing of the formal LDP was undertaken by the participants. The arrows indicate the progression of writing up of the plan with the expectation that close monitoring would occur.

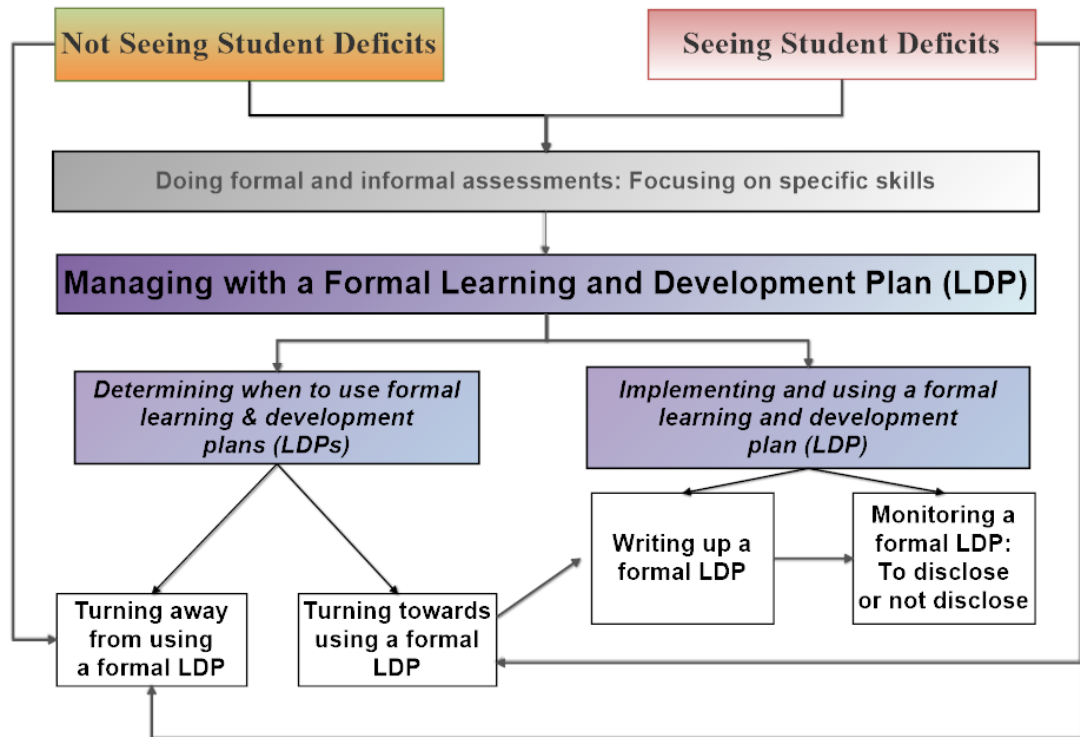


Figure 96: Managing with a formal learning and development plan

6.2.2.5.1 Determining when to use formal learning and development plans

This element outlines the approach that participants took towards the use of a formal LDP and describes how they either turned towards or away from using the plan. Each university provided CFs and students with a process for when students were reported as struggling. An LDP was tailored to the student’s specific learning needs and was formal recognition that the student had been identified as struggling. For students in a final placement, a formal LDP needed to be implemented promptly, so that the student could have enough time to make the changes and improvements specified by the LDP. The two sub-elements that describe these are ‘Turning away from using formal LDPs’ and ‘Turning towards using formal LDPs’

6.2.2.5.1.1 Turning Away From Using a Formal Learning and Development Plan

Participants indicated that they at times turned away from using a formal LDP. This occurred when HSS reported students had deficits that the participant could not see, when participants wanted to give students one or more chances to improve, and when participants felt the use of the plan would be threatening to students or themselves.

Fiona turned away from using a formal LDP in a situation where the HSS claimed a student had deficiencies in his practice. Fiona was asked, 'That young boy that you were talking about, did he go, did you put him on a learning development plan?' Fiona replied, '**I didn't need to** because there was nothing wrong with his **clinical skills**'.

Gemma also recounted how she managed by offering a struggling student another chance but saw that students did not always improve their chances: 'I said to him "**Listen this is the second incident. If there's another one**, we are going to put you on a plan" and there was another one. So, then we put him on a plan'.

Ashley reported on the detrimental effect a LDP could have on students and herself:

[A formal LDP] can be quite **detrimental to a student**. It's **seen** as a learning tool ... but **students' pride** can be **quashed** ... **it is no wonder** that facilitators don't put students on development plans early, because it **is** extra work ... And if we don't **feel supported** by the clinical office, in doing that, and ... all that its doing is, is causing more problems for them.

The use of the formal LDP could appear as punitive rather than being supportive. However, withholding information from the members of the HEP's clinical team could be cause for concern as students would require formal warnings. A formal warning was evidence that the student was aware of participants' and other nurses' concerns and was given an opportunity to address these deficits.

Debbie also indicated she would turn away from submitting a formal LDP to the HEP when she perceived her student would be adversely affected by dealing with the members of the HEP's clinical team:

I felt that I could do this, cause **I had** done a learning development plan with the previous university clinical coordinator ... I just wanted to keep it one on one because he ... had lost **all confidence in himself and** I just think that if I had got the uni involved, it would have been even worse, and he might have walked away, and **I didn't** want that to happen ... **I really [pause] tossed** up whether I should have got uni involved. I really did. Sometimes I get them to talk about a patient ... tell me everything you know about that patient, what you did for them and why you did it for them ... and it worked; he came good.

Debbie revealed how she strategised to minimise stress and conflict. However, she continued to question if she had done the right thing and continued to experience negative stress. Although Debbie reported her actions as using an informal LDP, other participants reported these actions as being the focussed assessments they had done either formally or informally.

In summary, participants turned away from using a formal LDP because students were not seen by them to be struggling or they wanted to protect students or themselves from further anxiety. Some participants viewed a formal LDP could threaten themselves or their students, or that they as the CF would not be supported. Others felt there was insufficient evidence that a student was struggling with learning to introduce a plan. In other instances, participants reported that they gave students one or more chances to improve their nursing practice or provided students with an informal LDP

6.2.2.5.1.2 Turning Towards Using a Formal Learning and Development Plan

Most participants described that they had in some situations turned towards using formal LDPs. This provided transparency, was fair to the student and would produce less anxiety in managing students who were struggling. Barbara described her interpretation of how the plan should be used:

You know if you're getting in the car and you **don't** give them a map of where they're going and how to get there and what they've got to do along the way. It's better to **address it up front** and be transparent about it from the **beginning** ... But it is there as a tool. It is not there as a threat and that it is their friend ... and it is my friend and it's making sure that it is all above board so that they can pass the prac. ... We have a professional development plan for them and say what we are going to do. Often, it's not the student's fault.

The interpretation of the 'map' appeared essential for successfully steering students in the right direction. As the plan was promoted as the student's friend and the participant's 'friend', this promotion indicated ease with having to use the plan; particularly if external factors contributed to students needing to be on the plan. Gemma also expected that a formal LDP was a process or a tool that would protect students from failure:

I think I was trying to protect the student **more than anything else** and the way I see it is the development plan doesn't mean you are just going to fail. It is a learning tool ... If you do everything that you should be doing on this plan and there are no further incidents, there's no reason why you can't pass.

Although Ashley considered safety to be an aspect of using a formal LDP, previous communications with a member of the HEP's clinical team had reinforced the need to act sooner:

The only time that I would really say that I have used it positively is in this most recent experience ... I suppose I was still feeling **burnt by the previous rotation** and put ... this second student on a development plan on day 2 ... You know, it **needed to be done**. When I **contacted** the clinical office, I said, 'Given last time, I am going to do this now'.

In using HTMETS, Ashley's action of turning towards using a formal LDP showed that she made this turn to prevent experiencing distress. Here she reflected on how to better manage students with the LDP. This action was perceived as positive and she was seen as owning up to 'self [as] an unfolding event, in the process of realisation' (Figure 20). It appeared she had more control over the process of implementing a LDP.

In summary, participants indicated why they turned away or towards using a formal LDP. The similarities between turning away and towards using a formal LDP were actions to protect students or themselves from distress. When participants viewed the LDP as non-supportive or a punitive tool, they were more likely to turn away from implementing a formal LDP. Participants turned towards using the plan earlier if they had experienced distress associated with not having implemented it in a timely manner or had experienced a positive approach to supporting student learning.

6.2.2.6 Implementing and Using a Formal Learning and Development Plan

Participants reported on how the LDP was implemented. The implementation process included writing up the plan and the deciding whether to disclose the learning objectives to HSS. The two elements of implementing a formal LDP were 'Writing up a formal learning and development plan' and 'Monitoring a formal learning and development plan: To disclose or not disclose'.

6.2.2.6.1 Writing up Formal Learning and Development Plan

Participants reported on who wrote the formal LDP. Participants would develop a LDP by seeking information from the student and support from individual members of the HEP's and HSP's clinical teams. These formal plans were either written by one of the members of the HEP's clinical team or by the participants.

Harry stated:

Umm, **they're individual**. They're not something that are, are, we don't have a drawer for this one fits this or fits that one. They're **quite specific and individual**. ... It's pointless writing a plan **unless** you involve the student and the placement area in it. Otherwise, it doesn't become realistic and it's **not** going to work. So, you sit with the student, hopefully with someone else from the facility and work out a plan and what constitutes an action plan. Otherwise, it doesn't work.

Ashley described who had input into the formal plan and how the plan was shared with the student:

They are made by me in **conjunction** with the university, with the clinical placement or person or coordinator. So, it is shared with the students. Signed by **both** of us with an assessment date identified ... Yeah, **I didn't have** the educational confidence to word it correctly, I think ... The second one, the one that was done **so late** in the student's rotation, again they sent somebody out, that person went back home, **developed the learning contract** or development plan, sent it through to me and I enacted it with the student. The third one I did myself, [long pause] with some tweaking [laugh].

The collaborative process of writing up and implementing the plan had increased Ashley's confidence to write them.

Debbie indicated that she thought various copies of the written plan were given to other nursing and academic staff:

So, the ward get given a copy and the manager, I suppose the manager gets given a copy and you would expect them to pass it on to preceptors or to the ones that are in charge for those shifts ... Students got a copy, I get a copy, uni has a copy and the board get a copy.

Debbie expected that the university's board of examiners would be given a copy of the written plan. Once an LDP was written and implemented, the student's progress was monitored. However, monitoring student development appeared to be complex.

6.2.2.6.2 Monitoring a Formal Learning and Development Plan: To Disclose or Not Disclose

Participants reported on the processes used to monitor a LDP and on their perceptions about having to disclose or not disclose written plans to HSS. Debbie reported how monitoring the student's progress was up to the CF: '**It's left up to us to monitor it.** So, the uni [beginning tapping] will put it into place and then it's up to us to monitor'. Likewise, Barbara reported on other nurses having to provide written evidence each shift they had worked with the student:

And I, they have that learning contract with them every day. And it's filled out every day and they understand that **yeah**, it's up to them ... Oh, they **certainly** should share it with the staff. It is **their** responsibility. If they've got a learning development plan that they have to achieve certain learning outcomes, then they **should be** sharing that with **their** preceptor. So, the preceptor can help them to achieve what **they needed** to achieve ... They get a copy. I get a copy. The university gets a copy ... And it seemed to me that if a student has a **different** preceptor, I've got to **re-educate** the preceptor every time as to where the student, particularly if the student is on a learning contract and they've got **four** or **five different** people **filling** out their **learning contract**, like, [pause] do you know what I mean?

To monitor the student's progress, participants read what other nurses had written about the student's progress. However, workplace attributes such as the transient relationships between students and CSs appeared to influence how effectively they could monitor and support students who were struggling. This narrative indicated that Barbara valued that other nurses understood how best to support the student.

Elly also considered that a shared understanding about student deficits was essential:

I think the only way it's going to work is if the person who is working with them every day knows what their goals are and knows if they've achieved them clearly.

Cause **how** will I know if they've achieved them? Cause **if** it's in writing they know what they're looking for and there's a way of working it out.

Both Barbara and Elly expected the student to own the responsibility and share their LDP objectives each shift with the CSs with whom they worked. Elly appeared to have greater confidence in students' achievements when she saw what other nurses had written. However, participants indicated that a new trend was not to disclose knowledge or evidence of a written plan to other nurses as this information was confidential. Sounding concerned, Elly reported:

What I'm seeing **more** and more and this is really even this year, with the learning contracts ... it's confidentiality and you **can't** tell the ward staff. It's **just** between you and the student ... So, the staff development nurse **wasn't** to know. The managers **weren't** to know. The ward staff that they [students] worked with **weren't to know**. It was **just between you** and the student. Which I thought was **absolutely crazy** when I am there 1 hour per week ... The preceptor **should** know!

Here Elly was confronted with not being able to be open about the learning and monitoring needs of struggling students. When other nurses were too busy to pay attention to students, the risk to patient safety was likely to be increased. However, Barbara argued that students, not the CF, were responsible for disclosing their LDP:

It's like saying you've got a map and you're driving a car and you're not, like **you're** responsible for your own learning ... and the person you're driving with ... you're **not going** to show them **your** map! And then **all of a sudden** it gets to a point and **you're** where **you're not** meant to be, and you say, 'Well, **why** aren't we there?' And they'll say [the preceptor], well **you didn't** show me the map. I mean, how **stupid** is that?

Although earlier she had valued enlightening other nurses about the need for supporting students on LDPs, Barbara recognised the right of the student to direct and manage their own learning. Here Barbara indicated that the student who did not show their 'map' of learning needs to their nurse supervisor was acting unwisely.

In summary, turning towards or away from using the formal LDP was dependent on how the LDP was valued, and its anticipated effect on students and on participants. Individual HEPs appeared to have different approaches to disclosing or non-disclosing

a student's LDP to HSS. Participants monitored students' achievement of objectives, but this appeared to be undermined when the participant's plan was not disclosed to HSS. The directive from some HEPs to keep information about struggling students confidential had conflicted with some participants' values of transparency and authentic practice; for others, the right of confidentiality superseded the value of being transparent in their practice.

As student LDPs remained hidden from their supervising nurse, the ability of the participant to obtain written evidence of daily progression and risk became more limited. As students might not disclose their learning and development needs to other nurses, a lack of readiness might not be identified and patient safety was at risk of being compromised. A lack of disclosure was likely to affect students in how ready they were and best supported to learn the role of the RN.

This concludes the second phase of the study 'Forging ahead'. The next section of this chapter describes the final phase: Phase 3—Reaching the destination.

6.3 Phase 3—Reaching the Destination

This next major theme of the framework is Phase 3—Reaching the Destination. It describes how participants determined if students were ready for the role of RN and how they recommended or did not recommend a pass for the student's practice. Ida clarified how she had determined when students had reached their destination:

You know, what I was looking for in terms of **understanding** ... on making **decisions** and patient informed consent and **all these different things** that they have **been there all along**, but suddenly they make sense. And they go 'Oh'. Light bulb moment. [laugh] **That was** when you knew that they were ready to take the next step ... that in the future I **want to nurse me** ... I think 'Wow, you've got it together and you're very interested in the bigger picture' ... if they have fulfilled all the requirements of the university in their prac.

Phase 3—Reaching the destination is illustrated in Figure 97 and is the last phase of the STR framework.

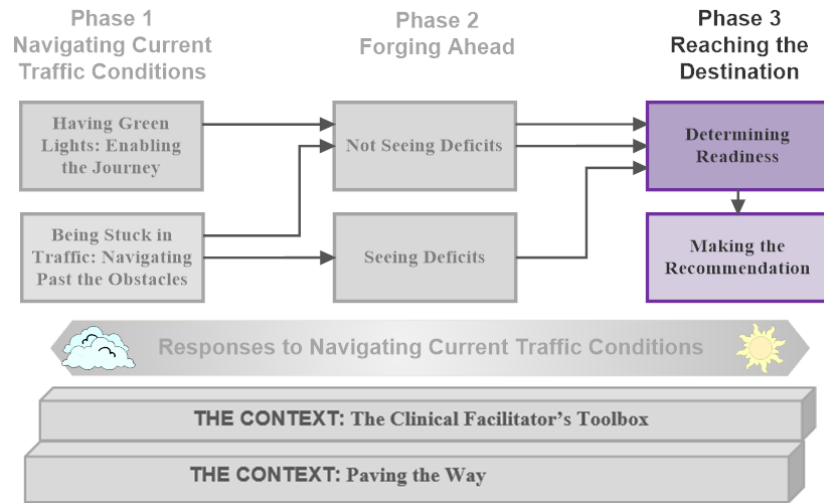


Figure 97: Phase 3—Reaching the destination

Table 11 outlines the themes and sub-themes of ‘Reaching the destination’.

Table 5: Reaching the destination

Theme	Sub-theme
Determining readiness	Expectations about work readiness & independent practice
	Expectations about competency & safe practice
Making the recommendation	Recommending a pass
	Not recommending a pass
	Managing conflicting opinions about passing or failing students
	Having another opportunity

The interrelationships among the concepts of ‘Reaching the destination’ are described as ‘Determining readiness’ and ‘Making the recommendation’. These interrelationships are illustrated in Figure 98. The segmented arrow arising from the actions of ‘Recommending a pass’ indicates how previous experiences of passing students may change how a CF expected readiness to practice should occur. The first theme of Phase 3—Determining readiness is now described.

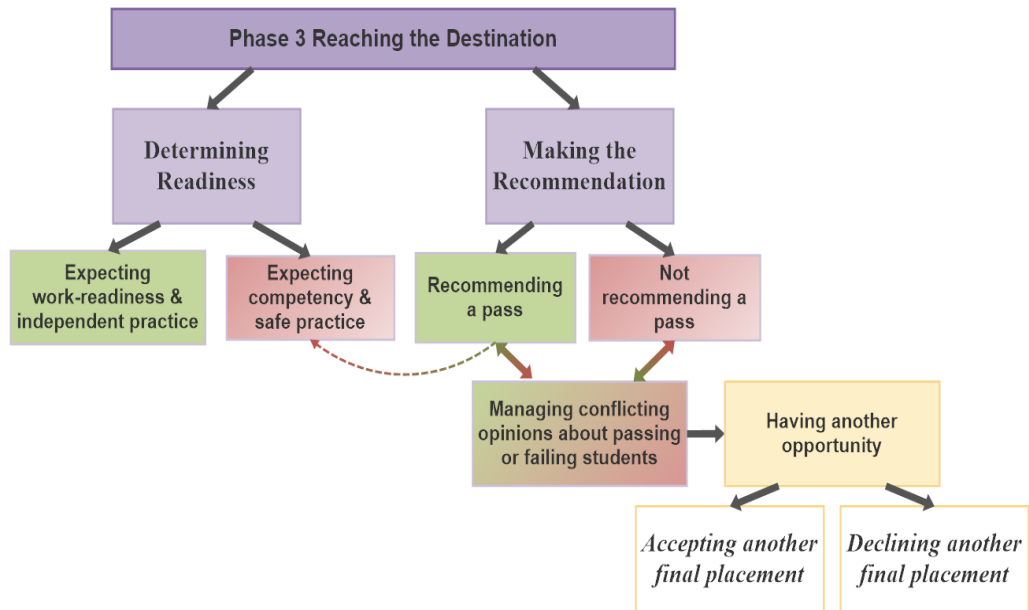


Figure 98: Determining readiness and making the recommendation

6.3.1 Determining Readiness

In determining readiness, participants used known terms to define readiness. These terms were expected to assist them to then make a recommendation about competency. Harry stated:

When they go from university to prac what I would like to think is that they are work ready ... But you've come to somewhere where you're utilising those skills and don't utilise the others. **It's an umbrella.** You teach a **little bit** about everything ... but you will know **nothing** in any great detail. So, depends on where you go to work, that's when you then develop your **expertise**.

To determine readiness, participants identified their expectations about the levels of independent or supportive practices that students were able to achieve in the current training, and practices provided for them. Figure 99 illustrates the interpretation of participants' expectations about readiness in terms of work readiness, independent practice, competency and safe practice.

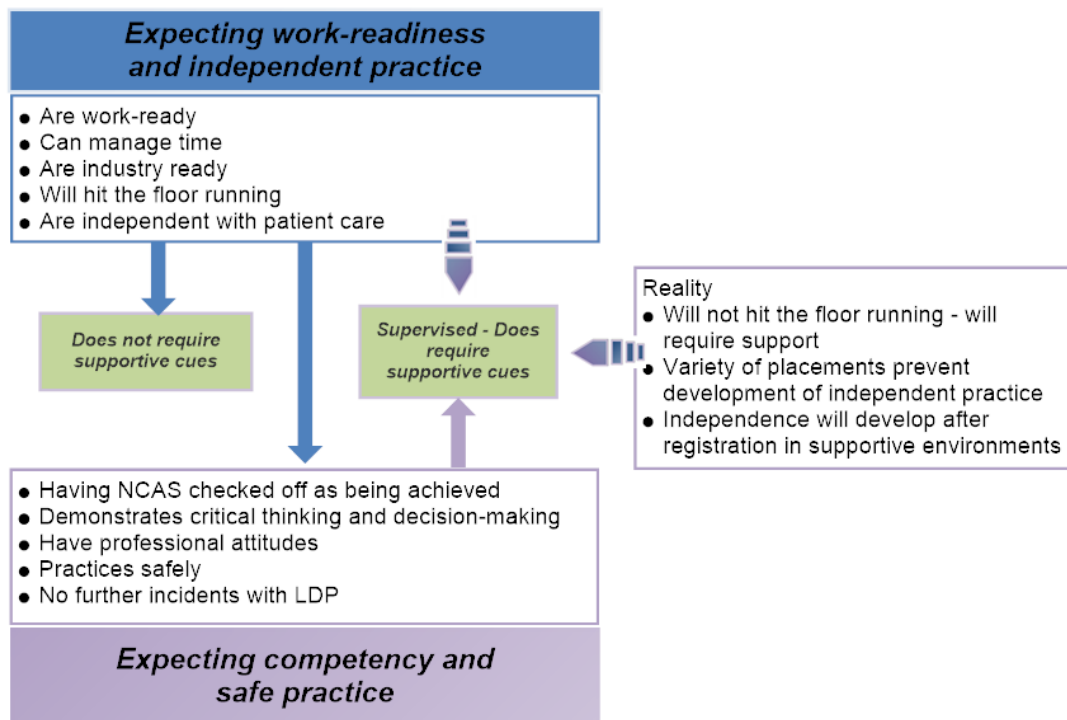


Figure 99: Determining readiness

The levels for supportive cues are included in Figure 99 to show where these concepts sit within the NCAS and with participants expectations about readiness. The fragmented arrows show how the reality of placements and practice had influenced how participants determined readiness. The two concepts that describe how readiness was determined are titled ‘Expecting work readiness and independent practice’ and ‘Expecting competency and safe practice’.

6.3.1.1 Expecting Work Readiness and Independent Practice

For students to become prepared for the role of the RN, some participants identified that their goals for students were to be independent, competent, to ‘hit the floor running’, be ‘work ready’ or be ‘industry ready’. Participants described their views on how students were expected to attain work readiness.

Gemma reported on the need for students to demonstrate that they were independent” ‘You need to be independent **not supervised** ... So, at that stage **they should** be doing it all themselves, and just having the RN to supervise’. This expectation matched CFs’ and HEPs’ expectations that final placement students would achieve independent levels of practice to deliver nursing care that a RN would manage.

Other commonly used terms also indicated that independent levels of practice were expected from nursing students. Ashley stated:

When we hear facilities talking about students not being industry ready, that to me says they have passed but they are not ready to work independently of the registered nurse ... **Being industry ready** means that you **can** manage your time.

Students on a final practicum were expected to be able to step in and manage basic nursing care. Elly stated:

You really have to be able to hit the floor running ... and I want more people at [HE#2] to see those students. To see what, what is the implication of putting them through when they're not ready and not preparing them for the workforce. Because it's, you **don't want** to see anyone like that. You know they say, say, 'I don't know if I can do this anymore. I want to quit. I want to change. I want to go'.

Here Elly saw the responsibility for not preparing students to be independent and ready for the workplace as resting with the HEP. Her expectations for a student to 'hit the floor running' as an independent practitioner were not met. Much support appeared to be needed.

However, Barbara expected that new graduates would not be at an independent level:

I **wouldn't** say they are independent. I'd say they could go out and practice if they enter into a grad program ... There is to some degree support that needs to be, maybe it needs to be **at arm's length**, but there **needs** to be some support program. That's **why** we have them.

Barbara indicated that students who completed a final placement would need support, practice and time to develop their nursing skills to this level. This expectation did not match those of other participants or HEPs' expectations that final placement students would be independent practitioners to take on the workload of the RN when taking up employment.

6.3.1.2 *Expecting Competency and Safeness to Practice*

Participants expected to see students attain a safe level of practice to assume the responsibilities of managing patient care. Elly reported on how she determined if students had demonstrated competency:

You know if they are ready or not ready ... There are **all** the skills they have to have ticked off. But it's the ones that **aren't** so black and white. So, the **decision** making and the critical thinking.

Seeing boxes ticked off in a student's NCAS did not necessarily mean that a student had attained competency in all expected areas of clinical practice. Ascertaining how a student could make decisions required more extensive deliberation on how students had met the RN Standards (NMBA, 2006).

Ida also reported on her expectations for students' readiness and competency:

I don't even say they are ready. I deem they are competent based on the assessment that I have given ... The expectation that they are going to hit the floor running is well written in literature. It's **never** going to happen ... Some students end up with community and then mental health and then they're on a surgical ward, so they can't be that.

Here Ida's words indicated that readiness to take up the role of the RN and being assessed as competent were not the same thing. She focussed on competency as students would not be able to step in and take up the load of the RN as an independent practitioner without support.

Barbara had assessed competency through the lens of unsafe nursing care:

And they will say 'So, what does unsafe look like?' And I will say medication errors, one ... It's **often** to do with the fact that you're coming to work 20 minutes late. That you're going to break without telling people and that you're leaving the ward without telling people. That ... you don't look up your acronyms. You're unable to give your handover. You don't report that someone's got a dressing that needs doing. You don't look out for a colleague. So, it's a range of factors and it is **often** an attitude.

The professional behaviour of students indicated how the student would safely provide care to patients. When students had a LDP and had demonstrated they could practice safely and professionally without incident, they would be determined as being ready to pass. Gemma reflected:

Yep, um, **yeah**, I think that male student that came across, towards the end everyone was saying no **he's fine**, he's changed and there's been improvement in his professional behaviour and the way he speaks to patients. But, but because of the incident that followed in the final week, I thought, 'No! He wasn't ready to move on'.

In this narrative, having a LDP did not prevent the student from further unsafe or unprofessional practice.

In summary, participants outlined various responses to determining readiness. The students who were considered work ready and independent practitioners did not require supportive cues and were also considered competent and safe to practice. However, students requiring supportive cues were expected to be competent and safe to practice but not necessarily work ready and independent. This expectation of beginning-level nurses to practice nursing care independently was perceived by some participants to be unrealistic; they considered that once employed, students who had demonstrated they could practice safely with support would then be ready to learn the role of the RN and become independent practitioners.

The next sub-theme describes how participants made a recommendation about passing or failing the student. These differing approaches indicated that students may have been generally ready to take on the role of the RN to practice safely but would be unable to attain an independent level of practice.

6.3.2 Making the Recommendation

Participants described how they made recommendations to the HEP that students should pass or fail a final placement. However, as identified earlier in 'Forging ahead' these decisions were based on the collected evidence and perceptions of participants, students and HSS. Participants carefully considered a student's level of independent and/or safe practice. Elly stated:

I honestly don't think I've ever failed someone that I have regretted failing. **I don't think that anyone that I've failed should not have failed.** It's **not a decision** you take lightly ... I do care about what I'm putting my name to. I couldn't sleep if I just signed off a piece of paper and I didn't believe I should be passing a student or should help them the best way that they could be ready.

The sub-themes are 'Recommending a pass', 'Not recommending a pass', 'Managing conflicting opinions about passing or failing students' and 'Having another opportunity'.

The first sub-theme to be described is that of 'Recommending a pass'.

6.3.2.1 Recommending a Pass

Some participants explained that they would recommend a student pass the placement. However, they also reported that students who were not ready could be recommended as passing students. The two elements described are 'Passing students who are ready' and 'Passing students who are not ready'.

6.3.2.1.1 Passing Students Who Are Ready

These concepts describe how participants passed students when they had articulated confidence, had insight, could critically think and had compassion. Barbara indicated that seeing growth in students' professional and clinical development was significant:

So, I would meet them in a different area at the end of their prac and we'd talk about what did you get out of it? What did you see? And **that's when** they could **articulate** how important this was and how this affected what they thought ... and often its articulating that, 'This is how I helped this patient' ... '**I could explain** this was what was going to happen'.

Caroline put herself in the shoes of the patient and had determined that the attribute of caring was a significant aspect of being ready:

Because this girl, her mother with MS and she cares for people and has this compassion. She cares for people ... So, we need those students who are going to be compassionate ... who's going to care for you. They're not going to be Einsteins.

Elly defined her bottom line for passing students:

What I assess for a student I want them to be, what I think is a **safe student to pass** as a semester final is that I want them to be **able to identify** their own **learning needs** ... They need to communicate safely ... They **have to have** insight and they have to know when to ask for help. But the end of the day when I'm thinking about whether they **are ready or not**, I want to know that they know what they know and don't know. And that they don't, um, **hide** their weakness. They're open and they say, 'No. I don't know that, but **I know how to find the answer**'. That's my [pause] my bottom line.

Although participants had reported on how they had expected students to be work ready, they had focussed on the safe practices and behaviours of the students. However, participants also voiced that although they had assessed and passed students as independent in their practicum, students were not work ready.

6.3.2.1.2 Passing Students Who Are Not Ready

Participants reported that they had passed or seen students pass who were not ready. Not all participants viewed being competent to practice as being independent or being work ready. Instead, some participants expected readiness would occur once students had registered and could develop in a supportive workplace.

Ashley perceived that students could pass a final placement with insufficient learning opportunities to become ready for the role of the RN:

When we hear facilities [the HSS] talking about students not being industry ready **that** to me says they **have** passed, but they are **not** ready to work independently of the registered nurse ... Even if we reflect on the student I spoke of earlier, I am really **struggling** to **get** her to take on a small patient load this week ... She finds it difficult because there is a team approach and that, um, autonomy if you like, or at least coordinate the care of two patients is difficult for her to do in **that** environment ... She could pass the prac with limited exposure to the opportunity to meet the scope ... So, if they can meet the scope according to the preceptor, she's met the coordination of her patients.

Passing the placement did not mean that the student was ready for the role of the RN. This part of the narrative indicated that during a student's practice, the opportunity to lead, be responsible for or manage a group of patients could be sporadic or that the

assessment of a two-patient load did not represent being able to take on a nurse's case load of patients and would affect in employment whether students could adapt to the role of the RN. Ashley continued:

I have seen her on her grad program down at [HSP#4]. When I first saw her in that 3 months, she was in a terrible state. '**Don't** know why I did it. **I should** have left. **I can't** cope'. **Really!** And I find myself **still** supporting this person after she had registered ... She had passed but was **not** ready. And **again, not** industry ready ... She was a shining example. When it was asked of me by the hospital, I gave a glowing reference. She was dedicated, conscious, but hit the wall as a registered nurse for that first placement, or grad program ... She knew she, she wasn't up to par for the pace of work and the expectations for being a team member on that floor ... She was competent in a supportive environment.

Ashley appeared shocked by the student's admission of not being ready to take up the role of the RN as she had recommended this student as an independent practitioner. The use of the phrase 'competent in a supportive environment' indicated that competency represented safe practice, but not independent practice.

Elly also appeared to struggle with previous students' revelations about not being ready to take on the role as a RN. She sounded concerned:

And you know more and more I see grads that that they're coming up to me and crying saying 'I had no idea I was going to be thrown in'. You know from students I've had in the past and they think they, they can then feedback to me and say, 'Look, I was not prepared. I was not ready when I stepped straight in' ... **they are thrown in um the deep end and they either sink or swim** and it's so many ... they all tell me how hard it was ... 'I didn't think I could do this. I went home crying every day'. Um, so many students say that they **were not ready** for that first 6 months.

Ida further clarified why she didn't use terms such as 'ready' or independent practice but had considered that developing the role of the nurse would occur after employment had commenced. She stated, 'The fourth year is the necessary part where they are then supported to be a nurse'. This statement indicated that students were safe to be out in practice but would require support to develop their practice.

In summary, participants used a mix of terms to describe a beginning-level nurse. Although readiness for the workforce as an independent practitioner was expected by some participants, the reality of the opportunities for practice did not allow students to be able to ‘hit the floor running’ on employment. Participants reported that to pass students, they considered students did not need extensive knowledge of all aspects of nursing to fulfil the role of the RN. Instead, participants expected students to demonstrate they could practice safely and know when to seek out help, could make clinical decisions that were sound and had insight into their own learning needs. Participants also passed students when they were confident that they would receive effective care from them should they become the patient. The next sub-theme describes why participants or HSS would not recommend that a student pass a final placement opportunity.

6.3.2.2 Not Recommending a Pass

Participants described why they would not recommend a pass and how this could be distressing for them and for the student concerned. The process of not recommending a pass was driven by HSS or participants. Harry relied on HSS to determine a student’s readiness to practice. He reported:

It wouldn’t be me failing them as such. It would be the RN supervising them that had enough concerns that they felt they couldn’t sign them off ... You can look at learning plan ... By week 3, if they are no further forward if the RN is not happy to sign them off, then I wouldn’t either. **I’m not going to override her**, his or her decision.

Gemma indicated that if she or HSS identified and assessed that a struggling student did not attain the expected objectives written in their LDP, she would not recommend a pass:

She was just not safe, and this was a final prac and I felt it was very, very sad as she had come **all that way**. It had taken her **4 years** and then to be told at the end, sorry you’re **just not safe**, you’re just not cutting it ... cause it was flagged early during her prac and even with specific goals and development plan and, working alongside her she didn’t get to the level she needed to be ... Her goal was to do a two-patient load and she **didn’t accomplish that**. By week 3 she had made very little progress and obviously failed her prac.

In summary, participants did not recommend a pass when a student did not meet the required standards and when participants had the evidence to support nurses' and participants' recommendation for failure. This evidence was obtained from the written comments of HSS in the student's LDP or the CF's written journal. However, at times the evidence conflicted with that of the participants' assessments.

6.3.2.3 Managing Conflicting Opinions About Passing and Failing Students

Participants reported how they experienced HSS who had differing expectations about the passing or failing of individual students. These differences appeared to be related to workplace attributes, doing focussed assessments and not relying on HSS recommendations for a pass or fail grade. Gemma reported that the process of failing a student was stressful:

That's the hardest bit is when someone comes and complains. And you say, 'Are you happy to put down in writing?' And they think, and they say, 'Oh no! I don't want the student to know who I am'. What **I did** was I made copies of **everything**. So, I made copies of his interim, his final, his final reflections that he did, **feedback from everyone** and I've put **everything** in emails, liaising with university, so I've covered myself. All the incidents, day to day and I've got copies for myself, so if I am called in, **I am not** going to forget any details.

This distress was related to not obtaining written evidence about the failure from other nurses. Gemma indicated the need to protect herself by having evidence that could substantiate her recommendation for not passing a student.

Fiona reported how she had disagreed with HSS that a student should fail his practicum and she also relied on having the evidence to make a recommendation:

Everything about him was good. There was nothing about him **that I could pick** and say right I have to fail you ... but **all** this happened **at the end of the prac** and my prac manager and I were just **totally surprised** that they were **insisting that he should not pass his prac** ... [I] passed him there ... I don't think they ever gave him any encouragement or help ... They were **all** set to have him fail, come **hell or high water**. They **didn't** want him to pass ... Well, they didn't have any evidence ... The whole unrest and emails occurred after his prac.

In this situation, Fiona sought the support of a member of the HSP's clinical team. However, disagreements between educational and health service clinical team members appeared to cause distress to members. The significant aspect to passing this student was a lack of evidence to fail him.

Ida reported that when working as a placement coordinator and a CF, she had noticed how HEPs were focussed on students passing a final placement:

And **if** there was an issue and I did have a couple of final-semester students where there was real issues with patient safety and them **passing** ... being more senior was ... I saying emphatically '**No! Sorry!** That really this student is not going to pass!'

This indicated that Ida also had experienced distress about the conflicting opinions between herself and the HEP. In this instance she was advocating for a fail. She also saw the need to use her authority as the placement coordinator of the HSP to refuse permission for the student to attain another placement in the setting.

In summary, the process of managing struggles with conflicting opinions appeared to heighten anxiety between HSS and CFs. To manage this effectively, the participants needed to have evidence to validate the failing or passing of students. If the student was not recommended to pass a final placement, the HEPs could give struggling students another opportunity to demonstrate that they could develop sufficiently to pass.

6.3.2.4 Having Another Opportunity

Some participants reported that struggling students were given another opportunity to practice, in the same setting or in another setting. This sub-theme describes how although students had the opportunity to take up another placement, some declined this opportunity. The two elements are 'Accepting another final placement' and 'Declining another final placement'.

6.3.2.4.1 Accepting Another Final Placement

Participants described how they saw struggling students given the opportunity to take up another opportunity to practice. Some participants were unsure about what

happened between failing the placement and being given another opportunity to practice. Gemma stated:

there's a stigma about students **appealing** their fail ... Apparently, students **have** the right to appeal their fail ... After they [HEP's clinical team] have gathered all the evidence and information, then they will decide whether they can overlook that fail and then **make** that person **pass** ... So, if he, if he is successful in that appeal, he will be given a pass and he will not be required to that placement. He will pass ... and if he isn't successful, it will mean that he will need to do another 3 weeks or 4 weeks [of] prac.

Harry was asked, 'When your students fail in their practice ... what happens from there?'. He replied:

They don't graduate and repeat ... So, if they fail the unit twice, they are terminated. If ... their last prac was a setting for example [a] mental health prac and they failed that prac for any reason, they might then be advised to re-sit the second unit, so just to make sure their knowledge is up to date ... But obviously if you fail a prac then there is an interview process and they will look at why that happened.

Harry perceived that a student would be expected to re-sit the theoretical component and an investigation would take place into the student's practice.

Ashley also recalled how personality clashes with a CF could result in the student failing a final placement. When one student was given another opportunity to practice, the student demonstrated that she was ready for the role of the RN:

A final-semester student who failed one of her clinical care placements in an emergency centre and then came to me in her second attempt at that placement and she passed. A lot of that had to do with her experience in the previous placement. Her interaction with her facilitator ... She was probably in the right setting, but she had the wrong support Well, when I met her, which was only a matter of 3 weeks later, she was more than ready. She just blossomed in the emergency department where I supervised her. The feedback from the staff was, 'Brilliant!'.

This may indicate that the student could have been ready, with appropriate support, but failed the placement based on a personality clash or bias from the assessing CF.

This aspect also linked back to seeing how students were ready when they still required support.

6.3.2.4.2 Declining Another Final Placement

Participants recounted experiences where students who were offered another opportunity after being removed or failing the last placement did not always take up this opportunity in that same placement.

Debbie reported that one of her struggling students had also declined an opportunity for another placement:

So, we had a bit of a talk and he didn't know his medications, he didn't know anything. So, at that time, the university clinical coordinator was the person to go to at [HEP#3]. She got involved and she came and interviewed him. She said '**Nuh!**' He had to do more stuff and anyway, she failed him. And she gave him the chance to come back and he didn't, and he's never finished.

Ida also recounted how HEPs wanted students to have another opportunity to do a final placement. However, in her role as a placement coordinator Ida would at times decline this opportunity for certain students:

So often I found that they would say 'Oh well you know we'll give them a second chance. They can come back. We'll take them off prac now and will you have them back?' And that was where I would be coming, 'No!' or 'Yes, we will give them a second chance'.

Ida's narrative showed that although HEPs offered students another placement, health settings could refuse to have the student back into the setting.

In summary, having another opportunity has described how failing students were offered another opportunity to practice. This opportunity appeared to give students a second chance to demonstrate they were ready for the role of the RN. Participants also thought that when students were not given a fair assessment, a second opportunity appeared to benefit the students and remove doubt about their ability to pass the placement. Participants also noted that students sometimes declined an offer of another placement.

6.4 Chapter Summary

In summary, these findings showed that participants determined that students were ready when they had demonstrated safe practice and professional behaviour; more than that of having independent practice to manage the workload of a RN. Although participants did not expect students to know everything, they expected them to make the connections between the practical application of theory and their nursing skills. Participants would recommend a pass if the HEP's requirements were met.

In 'Reaching the destination' participants described their decision-making process for passing or failing a student as complex, as participants needed to sift through the information to try to find the truth about how well a student was meeting the required objectives. The participants' narratives showed that HSS and participants sometimes experienced conflict about passing students. This conflict could extend past the period of a student's placement.

However, although participants had assessed and determined students as being ready as independent, when students entered the workforce they reported that they were not ready for the reality of the workplace. Some participants found this confronting as they had set out to prepare the students as independent nurses who could manage the workload of a RN and instead found them dependent on the support of HSS. This finding is linked to the inconsistent opportunities to practice decision making for total care of their supervising nurses' case load of patients and to the context of placement opportunities. Participants either questioned or reviewed how they viewed readiness to practice.

When students did not meet the requirements for the delivery of safe nursing care and having appropriate attitudes, they were not recommended for a pass. To fail students, participants needed to collect evidence from HSS and collate their own. However, it was not always possible to collect written evidence from HSS. Without this evidence, some participants felt they had little grounds to justify failing a student. Students who had failed a placement would usually be given another opportunity to practice and demonstrate that they could pass. Participants had assumed that upskilling of students would be given prior to being placed again.

Chapter 7: Discussion

7.1 Introduction

This chapter provides a discussion about the significance of this study's findings to the research questions, the conceptual framework and the existing literature. The purpose of this study was to explore the lived experience of CFs who I, A & M risk of graduating nursing students on a final clinical placement. Knowledge arising from this study has provided greater insight into how CFs manage the context of being the conduit between HEPs and HSPs, and how CFs might be better supported to manage this aspect of student supervision.

The two questions explored were: What are clinical facilitators' perceptions of the factors that may impact on the final-semester nursing student's ability to be ready for the role of the registered nurse?; and How do clinical facilitators identify, assess and manage perceived factors that hinder the final-semester nursing student's ability to be ready for the role of the registered nurse? The first part of this chapter briefly summarises the findings from Chapter 4–7. The second part presents the significance of the STR framework. The third part compares the findings with the current literature and the final part compares the themes of the STR framework with relevant theories.

The findings were described and interpreted in Chapter 4–7. This summary briefly describes these findings. The findings identified that the CF's lived experiences in supervising students in their final clinical placement is interpreted as a journey that is taken alongside students, faculty, HSS and a network of colleagues.

This journey was pre-paved by the providers and the curriculum, the nursing standards, supervision models, placement context, models of patient care and workplace culture. Metaphorically, taking this journey required a map or tools for guidance. The journey focussed on the lived experience of the CF and the tools that they took on this journey that facilitated the development of students and assisted the CF to steer the student past the obstacles they encountered. Although the CFs outlined how they identified, assessed and managed these risk factors, some CFs explained that they felt alone, as though their hands were tied and questioned if they were 'doing it right'. Some explained how they had kept quiet about the obstacles that students and

they had experienced. Further debriefing or support was needed by CFs to respond more confidently to the issues they were experiencing.

Moreover, CFs relied on themselves and/or on others to I, A & M risks, grade students informal and formal assessments. The reliance on themselves or others was dependent on the context of providers' expectations. They relied more on themselves to assess student competency when conflicting information was obtained from HSS or when HSS appeared hostile towards students or the CF. The CFs outlined how they would turn away from or towards seeking feedback, and from using the LDP when dealing with students who struggled. They also raised concerns about whose responsibility it was to disclose or not disclose the existence of a formal LDP to HSS.

The CFs explained how they and HSS graded students as being ready and how these assessments at times differed. The CFs indicated that readiness meant that beginning-level nurses were not independent practitioners who could manage a RN's case load of patients, but that after employment students would begin with safe practice and then, with a supportive team, learn to practise independently. The information above is related to details provided in Chapter 4–7. The next section reiterates the STR framework with the major themes, themes and sub-themes shown in Figure 100.

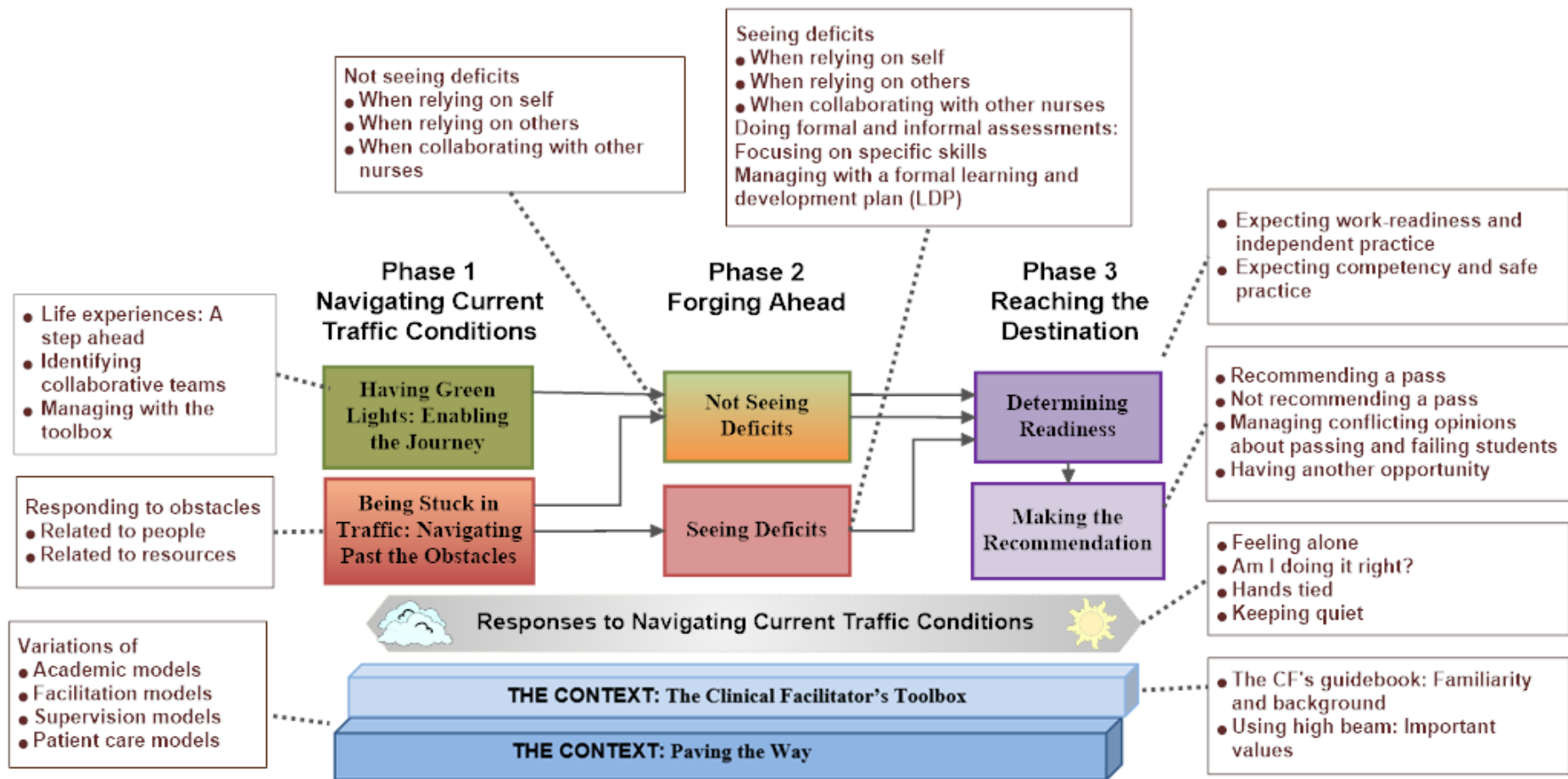


Figure 100: The Steering Towards Readiness framework with major themes, themes and sub-themes

7.2 Significant Aspects of the Steering Towards Readiness Framework

The findings of this study identified how the CF was able to respond to and navigate their way past the issues related to organisational structures, curriculum requirements, people and resources. The STR framework illustrates the context and the cycle used to I, A & M risk to final-year students' readiness during a final placement of their degree.

Elly responded to the emerging frameworks of the STR framework at the second interview. She stated:

I do mainly semester 4s and final students and I have more control over what they see and hear as an earlier-on facilitator ... [with] final-semester students you feel less in control and you ... have to have more experience to know all those things that impact the outcome ... With this theme the driver, I find it's really important to **set goals** for the students and **encourage** them to set their goals (yep) I think that's a **big thing** that you can drive. we have to **drive and direct them** so that they know what's expected. Cause a lot of them come in and they don't know well, where, **what should I look like** at the end. So, we can make them see what they should be doing and help them **get** there by simple things; by setting short-term goals on a daily basis.

Barbara also responded to the STR framework at the second interview. She stated:

I know as a driver, I make my own assessments. I **don't** always just rely on someone else. **In fact**, I might do my own assessment and I might query what others have written. I don't always take that at face value. I will **always do** my **own** independent assessments.

Harry stated:

When they go from university to prac what I would like to think is that they are work ready ... But you've come to somewhere where you're utilising those skills and don't utilise the others. **It's an umbrella**. You teach a **little bit** about everything ... but you will know **nothing** in any great detail. So, depends on where you go to work, that's when you then develop your expertise.

The next section compares the findings of this study with the relevant literature.

7.3 Comparison With the Literature

In this section the similarities and differences between the literature and the findings are outlined. The identification, assessment and management of students at risk had previously been identified as a process that occurs in steps or stages (Craven, 2015; Duffy, 2013; Gregory et al., 2008; Hunt et al., 2016b). Steps were identified by Duffy (2013) as seeing the early signs, developing an action plan and failing students as needed. Similarly, Craven (2015) considered the process involves steps of ‘being present’, ‘setting a new course’ and ‘being objective’. The current study attempted to identify how the participants managed struggling students in the context of the factors that hindered the students’ progress. These steps are outlined as identifying risks, assessing risks and managing risks.

7.3.1 Identifying Risks

The CFs noticed, found or linked internal and external factors of risks. These risks arose from the structures or the contexts of the providers and the CFs’ toolbox, the attributes of individuals and the workplace, the mismatch in use of resources and the relationships with HSS. Compared with this study’s findings, the literature as discussed in this section, relates to the factors that ‘hinder readiness’, ‘the clinical facilitator’s toolbox’, ‘obstacles related to student characteristics and workplace relationships’.

7.3.1.1 Factors Hindering Readiness

Various authors have reported on factors such as structures in the CLE that reduce opportunities for students to practice or increase the difficulty in assessing students for readiness. Factors of risk related to the structures used in the CLE in this study appeared similar to those reported in other studies. These were curriculum requirements (Brown & Crookes, 2016b), approaches to clinical placements (Birks, Bagley et al., 2017), supervision (Brammer, 2008; Broadbent et al., 2014; Duffield et al., 2010; Lawrence, 2014; Nash et al., 2009; Russell et al., 2010; Walker, Dyer et al., 2013), nursing care (Alderman, 2017; Coyne & Needham 2012; McInnes et al., 2015) and the skill mix and demands of the workplace (Brown & Crookes, 2017; Duffield et

al., 2010; Walker, Yong, et al., 2013). These factors influenced how the student, the CF, HEP faculty, HSP, managers and CSs were able to negotiate desirable learning opportunities.

The literature review reported on how HSPs and specialty areas influence a student's ability to practise nursing care. It seems that both task and patient allocation models could be beneficial to student learning as it is the quality of support that is significant rather than the model of support (Duffield et al., 2010). In contrast, the current study found that participants saw the need for students to undertake the holistic care of patients through the patient allocation model as this approach gave students the skills necessary to prioritise and make decisions about patient care. Although participants empathised with CSs, who needed to attend nursing care and supervise students using the team approach to nursing care, the participants' focus was on directing students to undertake care for a group of patients that the RN would manage.

Team nursing gave students the ability to observe nurses interacting, but the belief of participants was that team nursing appeared to be another name for the task approach. Learning in the team environment may explain why students were not able to manage decision making and prioritising of patient care once they were registered. This approach was likely to deceive students about their ability to manage patient care. As the team approach could lead students into thinking they were ready, it was likely that the assessors were also led to this assumption.

Similar to other studies (e.g., Cashin et al., 2017), the participants voiced that other RNs or CFs did not always match the students' nursing exemplars and practice to the specific parts of the nursing standards. However, unlike Cashin et al.'s (2017) findings, the participants in this study considered they understood how to read and interpret the students' exemplars with respect to the RN Standards. Understanding the assessment tools was an asset to the participants in the identification, assessment and management of risk, and was part of their toolbox.

7.3.1.2 Clinical Facilitator's Toolbox

The concept of the toolbox, toolkit or tools is not new. HWA (2010) referred to a CS's survival toolkit and Volpe (2011) referred to a toolbox of tools and knowledge that would lessen moral distress. Although Needham et al. (2016) sourced Australian CFs'

perspectives to develop a BPCF, she did not specifically mention a toolbox or a toolkit. However, she outlined concepts of best practice that should be part of the CFs toolbox. In the current study, the most significant enabling aspect of the participants' journey was the tools, experiences and strategies that they had in their toolbox.

Needham et al. (2016) identified that BPCF includes three aspects: assessing, learning to facilitate and facilitating effectively. Needham et al. (2016) recommended that to facilitate effectively requires formal preparation. This requires knowledge about formal and informal assessments. Participants also needed to maintain their knowledge, develop networks, model professional behaviour and utilise a high level of communication skills.

Similar to these findings, participants assessed general and specific needs for themselves and students. They also assessed the local environments where students were placed. Also similar to the theme of 'learning to facilitate' in the study by Needham et al. (2016), participants utilised networking. However, as they had little formal training in this technique they learnt by trial and error and deduced how to manage risk. The various expectations used by HEPs to manage risk had differed.

Participants also reported on facilitating with tools that required the exchange of information with professional nurses, the best use of experience and the deployment of skills. The CFs' tools consisted of specialty and facilitation skills, knowledge, resources and their personal, clinical or academic experiences to build productive relationships. Having sufficient equipment in their toolbox enabled them to take control of the facilitation process and make sense of the risks associated with students in the placement areas. Without these, the CFs were more constrained in how they could remain in control of the identification, assessment and management of risk. However, unlike Needham et al.'s (2016) findings, the participants did not match up the preceptors with students but relied on HSS to do this when students struggled and needed more focussed support.

Karlstrom (2018) identified that CFs in Canada value honesty, scrupulousness and precision in their students, as well as them taking control of the facilitation process. Likewise, this study found that the CFs in WA valued honesty. Honesty was considered an enabling tool in the CF's toolbox. Participants valued being open about

the realities of the workplace, knowing the learning objectives and having trusting relationships with students, HSS and faculty members. In this study, participants also valued being open and valued the nurturing of students. The latter finding contrasted with that of Walker, Dwyer et al. (2013), where students perceived the nurturing or ‘mothering’ role was less effective than the preceptor or CS model.

Similar to Mackay et al.’s (2014) findings, the participants identified that having a background in academia was a significant asset for the role of facilitation. Having familiarity in a specialty area also meant that participants could better assist with student learning and development, especially when HSS did not welcome students. Participants also valued familiarity with clinical expertise, HSS and students. Not having familiarity meant that CFs lacked confidence in the facilitation process and had an increased reliance on HSS to undertake the identification, assessment and management of risk to readiness. In these circumstances the participants’ role was limited to that of liaison.

Needham (2014) recommended that it is essential to develop BPCF support by inviting the CF to formally and informally share experiences with other colleagues and academics. However, some participants in the current study wanted to know more about the professional boundaries when working alongside other CF colleagues who were struggling, were new to the role or were from another HEP. These findings also support Needham’s (2014) recommendation for greater networking support, feedback and debriefing with academics.

HWA (2010) identified the core skills necessary for RNs who take on the role of the supervising nurse: clinical skills and knowledge, adult teaching and learning skills, ability to give and receive feedback, communication, appraisal and assessment skills, remediation of poorly performing students and interpersonal skills. In comparison, the WHO (2016) enumerated five additional skills for the facilitation of students: research, ethics, management, leadership and advocacy. The core skills necessary in this study appeared to be that of identifying, assessing and managing risk within the boundaries of providers expectations. The absence of debriefing and feedback had limited opportunities for the CF to develop these core skills as identified by WHO (WHO, 2016).

Birks, Birket, et al. (2017) outlined the need for the health service organisation to be prepared to receive and orientate final-year nursing students. Needham (2014) also found that BPCF in preparation for a student's placement is a process of planning, providing orientation and of utilising available resources. In the current study participants described the need to orientate students to the health setting environment, staff, specialty areas and the HEP's expectations for a final placement. Orientation practices began before the placement and continued throughout. This finding mirrors that of Needham (2014) with regard to planning, providing orientation and utilising resources that were available.

Needham (2014) found that if the CF does not place students with a CS, HSS will not supervise students. In the current study, the participants had little control over to whom students on a final placement were assigned for the placement, or over the allocated shifts. The times that the participant did take control were when a student was struggling. Participants would request that managers allocate, change or prevent the student from having certain supervisors. As such, the CS or preceptor designations remained the responsibility of the HSPs as they appeared to have an overview of nursing skill mixes and the demands of the workplace.

Broadbent et al. (2014) recommended that HEPs prepare CSs for the impending arrival of students. Although the CF was seen to be the bridge or the connection between organisations, the CF did not prepare the CSs about the arrival of students. This role appeared to belong to the HSP who knew the skill mix of the nursing staff. When students struggled in the placement, it was then that participants would actively seek out consistent supervision from the clinical managers.

7.3.1.3 Obstacles Related to Students' Characteristics

Craven (2015) described the experiences of academics who notice 'red flags' of underperformance (p. 65). These red flags are related to student attributes. In the current study similarities were found with Craven's reported risks in student attributes, such as CALD, mental health issues or personal issues or experiences. These 'red flags' were seen as indicators of increased risks to readiness. Similar to Skingley et al. (2007), participants also identified that students who struggled lacked essential

professional attributes such as motivation, theoretical knowledge and self-awareness, and thus failed to progress.

According to Hunt et al. (2016a), UK mentors, practice education facilitators and link lecturers navigate and manage student traits or characteristics of ingratators, diverters, disparagers and aggressors. Coercive strategies of students were considered of concern. In the current study participants identified additional risks such as having a previous working background, CALD that prevented learning, worrying about other responsibilities, being introverted or quiet and being anxious. The traits of risk that were similar to Hunt et al.'s (2016a) study were being charming (ingratators and diverters) or being intimidating (disparagers and aggressors).

Charming students were seen to be able to mask a lack of competency from assessors and when identified, it was too late in the placement to provide remediation. If assessors were inexperienced and struggling students were not identified, the student was passed as being ready for the role of the RN. When HSS opened up about the manipulative traits of students, the participants were able to guide the CSs as these staff were expected to grade students on the practices they had observed.

Other traits recognised by participants in this study were traits of the disparager and the aggressor as some participants had experienced threat and intimidation when giving students negative feedback. Hunt et al. (2016a) considered that supervisors needed courage to manage aggressive students and supervisors felt emotionally exposed and physically threatened. They also did not want students reporting them to a higher authority. However, in the current study, participants reported they would confront students about this behaviour.

A trait that was of concern in the literature was CALD (Deegan & Simkin, 2010; Jeong et al., 2011), nurses who were settling into another country and their managers (Sherman & Eggenberger, 2008). Deegan and Simkin (2010) assessed English competency and found risks related to language use, the quality of communication and the non-recognition of professional skills by local nurses. Deegan and Simkin (2010) recommended that it is essential to continue to explore the challenges associated with NESB.

Similar to Deegan and Simkin's (2010) findings, the participants in the current study recognised that international students with CALD were at increased risk of communicating ineffectively. In this study, some participants struggled to assess a student's use of the English language while others did not. Only one participant outlined a rubric she used to assess students in this skill. It is likely that a comprehensive tool to assess CALD would benefit or guide CFs in their assessments.

Similar to Sherman and Eggenberger's (2008) expectations for orientation, the participants sought to utilise the orientation period to outline practice, aspects of medication, communication, assessment skills; and to utilise therapeutic communication with patients to remind students of placement and assessment expectations. However, the participants focussed on the students' responsibility to seek out opportunities to practice, question their communication skills and communicate with other professionals. In this study, the obstacles related to workplace relationships influenced how students were able to progress and how CFs were able to identify risks.

7.3.1.4 Obstacles Related to Workplace Relationships

Workplace obstacles in the literature were identified with the structures associated with supervision and facilitation of students on a final placement (Broadbent et al., 2014; Ryan & McAllister, 2017; Walker, Dwyer, et al., 2013). Walker, Dwyer, et al. (2013) identified that their participants favoured the CF model of supervision and concurred with Duffield et al. (2010) that the quality of supervision was more significant than the structure of supervision. Similarly, participants in this study identified that although variations to supervision and facilitation occurred, the quality of the students' support was of higher priority.

Walker, Dwyer et al.'s (2013) expectation was that supervision or facilitation should maximise student development. In this study, participants also expected student development should be maximised. Participants perceived that specialised knowledge and experience were essential for maximising student readiness. However, if the participant had specialised knowledge and expertise, they felt more in control to I, A & M the learning needs of students. The CFs' specialty expertise was also likely to assist them in making sense of students' practice in the context of the specialty.

In specialty settings where participants did not have the clinical expertise or were unfamiliar with facilitation, they relied on HSS to identify and assess student issues; some participants struggled with not being in control of the assessment process. Participants lacked confidence when they were unfamiliar with specialty needs. Consequently, the participants relied more on HSS to I, A & M student readiness. However, at times the HSS who supported students were not RNs but were ENs and their assessment of how the student was progressing was sought. Nash (2007) also recognised that ENs and AINs would support students, but this was counter to Nash's (2007) expectation that it was RNs who would guide and supervise students.

Ryan and McAllister's (2017) study reported that ENs were used to assess a student's progress across nursing divisions. Although they recognised that ENs had similar skills to those of the RNs, the authors raised concerns about the extent of using ENs to supervise students across nursing divisions. An EN's assessment was more likely to identify if students were struggling with specific tasks associated with nursing. The HSP's policy of allowing ENs to preceptor across nursing disciplines meant that they were seen by Ryan and McAllister (2017) to be at times inadequately prepared for students. However, the authors reported that ENs struggled with not being accepted by students as their supervisor.

Participants in this current study utilised feedback from AINs, patients, ENs and RNs. In the aged care setting students and RNs were seen to have increased reliance on the EN's input about nursing care of residents and the student's capability to perform nursing care such as patient assessments and dressings. The participants questioned how appropriate it was to have an EN evaluate the performance of a student on a final placement. As the EN's role has continued to expand, the EN may have enough experience to I, A & M a student on a final placement if they can complete the tasks for a group of patients. However, participants in the current study felt that the EN could not determine readiness for the role of the RN.

Although Missen et al. (2016) indicated that the ENs in their study had evaluated new graduate nurse performance, they found that ENs who had transitioned to being a RN focussed on the completion of tasks rather than on making independent decisions to lead nursing care. It was expected that RNs would have more leadership responsibility and would perform more complex procedures than ENs (Jacob et al., 2017).

Participants concluded that students required more from their supervising nurses who were ENs. Further exploration of how the EN either hinders or supports students on a final placement is needed.

The literature reviewed revealed researchers' concerns that students appear to have been sheltered from taking responsibility for total patient care (Missen et al., 2015). Similar to the expectations of the Department of Health and Human Services (DOH, 2016a), the participants in this study had expected students on a final placement to have more opportunities to deliver independent nursing care. However, the findings concurred with those of Missen et al. (2015), who reported that the opportunity was not always given to students to practice at the level expected of a RN. Missen et al. (2015) recommended that both HEPs and HSPs work together to increase the quality of structured transition programs and the quality of students' clinical experiences. In the current study further insight was obtained on how CF relationships worked within and across systems.

Participants in this study outlined how they built relationships with HSS to take control of student learning. This finding mirrors McAllister et al.'s (2014) conclusions that workplace cultures should build effective HSP-HEP relationships. However, the ability to take control of student learning was dependent on the time allocated to support students and on the type of placement agreement, which determined how communication and support with students and HSS would occur. The CFs' values appeared to drive the need to take control of the identification, assessment and management process by building relationships with individuals. In a place where the CF liaised rather than actively identified, assessed or managed risk, they were dependent on HSS to perform more of these roles. It was these variations to the role of the CF that explained how connections could exist between seeing or not see deficits.

Shahsavari, Parsa Yekta, Houser and Ghiyasvandian (2013) reported on the CLE where disputes among HSS emerged and were seen to create conflict between the CIs and students. In this study, the disputes centred on conflicting feedback about progress, conflicting expectations of how to practice clinical skills or the need to fail or pass students. Participants relied on their experience, knowledge about the cultures of the workplace and the evidence obtained from assessing students to make decisions

about passing or failing students. They also learnt from these disputes and refined their facilitation processes to build rapport with nursing managers to decide who to trust and when to weigh up the feedback and keep good records of their communication. In contrast to Shahsavari et al. (2013), disagreements among HSS did not appear to affect the participants' relationships with students.

7.3.1.5 Seeing or Not Seeing Deficits

Karlstrom (2018) noted that to see deficits, CFs remained in tight control over students' learning activities to ensure the safety of patients and students. However, academic nurse educators were also seen as outsiders who were not always familiar with the routines of the health setting. The current study attempted to focus on the shared responsibility and accountability with HSS and students. Similar to Karlstrom's (2018) findings, this study identified how most CFs on a student's final placement wanted to remain in control of identifying, assessing and managing risk to readiness and that at times CFs were considered and treated as the outsider.

Participants in the current study relied on themselves or others or used a combination of these approaches to determine a student's readiness. When participants supported students in unfamiliar settings or specialties, were inexperienced or were expected to act as a liaison nurse, participants relied more on the assessments from HSS. In this study, being treated as the outsider influenced how CFs responded to the identification, assessment and the management of risk as it meant that participants were unable to obtain adequate feedback about students' progress.

Brammer (2008) explored students' perceptions about the role performed by their informal nursing supervisors in the primary care setting and identified that more information about how informal encounters occurred between RNs, students and CFs should be obtained. The current study has identified how the sharing of identifying, assessing and managing of risk is enacted by nurses and CFs. The study found that inexperienced CFs rely more on their assessment as they do not have familiarity with HSS, and experienced CFs who make up for the gaps in the assessments of HSS.

Although Brown and Crookes (2017) recommended the use of guidance notes, the participants did not have guidance notes to assist them to identify or assess deficits in student competency. The participants appeared confident in how to assess students

against the RN Standards. However, CFs who relied solely on themselves were more likely to miss risks or the deficits in a student's practices. The participants acknowledged that they did not always see deficits of a student and this was related to a lack of familiarity with facilitation, education, specialty skills, the hostility of HSS or dependency on HSS in the liaison role. Similarly, HSS did not see deficits when they lacked interest in students or if they did not have time to assess students. These factors were seen to increase the opportunity for students to pass the placement when they were not ready. When these situations occurred, the gatekeeping role as mentioned by Brammer (2008) became an open doorway to unsafe practice. The best way to ensure students were safe appeared to be the cooperative process that occurred with both HSS and the CF undertaking the identification, assessment and management of risk.

To see deficits, the use of a shared partnership and responsibility for the assessment process enabled participants to pick up on gaps in the assessment processes used by HSS. Participants would undertake more informal assessments to assure themselves of a student's progress. In Mackay et al.'s (2014) study, the partnership model did not include the views of HSS. Similarly, this current study did not capture the lived experiences of other stakeholders but supports the significance of Mackay et al.'s (2014) concept of close partnering among all stakeholders for the identification, assessment and management of risks to readiness.

7.3.2 Assessing Risks

The process of assessing risk was undertaken to determine risk factors and to make a decision about what actions should be taken. The literature recognises aspects of belongingness, trust and unprofessional behaviour as affecting student readiness. The literature also addresses how readiness is determined.

7.3.2.1 Belongingness and Trust

McInnes et al. (2015) reported on the key enablers for relationships, such as being welcomed and experiencing belongingness. According to Levett-Jones and Lathlean, (2007), optimising relationships in the placement setting engenders a sense of belongingness. Doyle et al.'s (2017) findings support those of these authors as the

culture of the working environment, positive work ethics and team morale were found to affect a successful placement experience for students.

In Levett-Jones and Lathlean's (2007) study, a sense of belongingness arose when individuals experienced connectedness and esteem. Belongingness included a sense of feeling secure, accepted, included, respected, connected and in harmony with group values and actions (Levett-Jones & Lathlean, 2007). These authors concluded that consistent high-quality mentoring would ensure students felt connected to the workplace.

The current study supports Levett-Jones and Lathlean's (2007) findings that being accepted as part of the team is an enabler for readiness. However, in this study trust was strongly associated with belongingness. This finding supports Doyle et al.'s (2017) recommendations that industry partners should build trusting partnerships.

Similar to others findings, participants in the current study saw students being disadvantaged (Borrott et al., 2016) as students did not have consistent, high-quality supervision (Levett-Jones & Lathlean, 2007) and the placements were too short and infrequent for them to build relationships with HSS (Levett-Jones & Lathlean, 2007). Students who were not welcomed by the HSS were less likely to be trusted with patient care and their assessments were likely to be influenced by this bias.

The participant CFs also found it difficult to obtain consistent feedback from supervising nurses. A lack of feedback reduced participants' ability to assess students' adequately. To gain accurate feedback from the CSs, participants learnt that they needed to ask directed questions about specific aspects of nursing care.

To manage the transient or hostile nature of supervision, participants turned towards building relationships with managers of clinical areas and seeking feedback from them about a student's progress. Participants also deliberately nurtured the building of trust with students. When CFs could get into the student's world and obtain the student's trust, the student was more likely to feel safe, respected and assured that the CF would support them in achieving their learning objectives. Participants behaved in a manner to develop student belongingness through orientating them to final placement expectations and by understanding their past experiences.

Doyle et al. (2017) recommended HEP educators should build trusting relationships with industry providers. Participants in this study attempted to bridge gaps in their relationships with HSS. However, participants were not always able to bridge these gaps with HSS who did not welcome CFs or students. Participants who had engaged in the identification, assessment and management process and used focussed assessments had relied more on their own assessments than those of HSS.

7.3.2.2 Effect of Unprofessional Behaviour

The literature provides examples of unprofessional behaviour of HSS, CFs and students (Hopkins et al., 2014; Hunt et al., 2016a; Reid-Searl et al., 2013). Similar to these authors, the participants in the current study identified instances of hostility and unsafe practices that would undermine student confidence and affect patient safety. The assessment of unprofessional behaviour was either within or outside the participant's control. As other nurses supervised students, participants in this study were not in control of the performance or assessment of skills. This finding is similar to those of Karlstrom (2018).

The current study identified how CFs responded to unsafe practice of students and other nurses. To manage the unprofessional behaviours of others, the CFs appealed to students to be responsible and accountable for their actions. Levett-Jones et al. (2017) developed an assessment tool to assess 'safe' practice of students when providing nursing care. According to Levett-Jones et al. (2017), supervisors could observe, question, assess and measure students' provision of safe care. However, participants identified that practices in the use of resources at times conflicted with their expectations for occupational health and safety standards, the latest best evidence or as directed by the policy of the health setting.

As belongingness occurs with the adoption of the group's behaviour, expecting students to practice counter to these poor practices was likely to push the student outside the bounds of belongingness and result in less opportunity to practice or an adverse outcome for the student or patient. These findings are concerning for CFs as they rely on accurate feedback from HSS and will need to make up for any gaps that occur in the assessment and supervision processes of students.

In the current study, the participants observed students giving out medication under the supervision of the RN as this appeared to give the participant clarity about the assessment process. However, some participants would not watch students and supervising staff as they believed that supervisors felt threatened by this approach. Participants also questioned students' knowledge about medication use and side effects and expected them to demonstrate how they accessed drug information and used a time management grid.

Hanson and McAllister (2017) linked the students' sense of vulnerability and disempowerment to being unaware of the realities of workplace cultures and practices. These authors advocated for the use of an emancipatory teaching model to develop skills of doing, being, realising, critiquing and visioning in students to reframe and reflect on the stressors. This model appears significant to a final placement student who requires inclusion and opportunities to practice as part of the team.

In the current study, the participants did appear to utilise skills of doing, being, realising, critiquing and visioning in their practice. Participants expected students to understand what they were doing and why they were employing the skills the way they were. They also expected students to reflect on behaviour, gain insight and judge the behaviour against the expected standards and the taught theory. The CFs also appealed to students to look forward to a future that represented safe practice and were empathetic towards HSS who had to meet the demands of the workplace as well as the supervision of a student.

Vulnerability had also been identified in acts of unprofessional behaviour such as physical or non-physical aggression of RNs, CFs, students and patients (Birks, Cant et al., 2017; Budden et al., 2015; Hopkins et al., 2014). These authors found that aggression caused students to feel threatened and become anxious, feel unjustly treated, lose confidence and be at risk of providing compromised care. Aggressive attributes of students also increased the likelihood of failure. As this was likely to negatively affect student competency this study attempted to identify instances where CFs identified, assessed and managed issues of bullying and aggression.

This study uncovered hostility of the HSS towards students and themselves. Hostility towards students was found to limit student opportunities for practice and the

development of confidence. It also prevented students from receiving fair assessments and increased their anxiety. Hostility towards the CFs' meant they did not receive accurate and timely feedback about a student's progress.

The CF who threatened students with failure for not complying with policy could be viewed as being hostile to the student. In consideration of the differences in practices and the likelihood that participants felt responsible for safe practice of students, the threat was an attempt at remaining in control of student behaviour. Further investigation into how these personality clashes are related to processes will provide further insight into how personality clashes are process orientated.

7.3.2.3 Determining Readiness

Kealley (2012) recognised that undergraduate training had not fully prepared students to manage comprehensive care of patients: they lacked knowledge and needed support. Kealley recommended that a transition period be made mandatory for nurses entering the workplace. In this study, it appeared that most participants assessed students for both specialty and general readiness. Readiness meant that students were expected to be able to step into the role of the RN confidently and to practise safely. However, as Kealley (2012) found, graduating students needed continuing support to practice confidently. Students also needed more time to develop a practice that was autonomous or be able to 'hit the ground running'.

Terry (2013) found that the supervisor's assessment decisions were based on the individual's skill of interpretation and practical wisdom rather than on the linking of the RN Standards to the student's nursing practice. As such, tensions existed between individual nurses about the RN Standards and the assessment of competency. This study attempted to identify how CFs in WA assessed students practice of nursing according to their HEP's requirements.

Brown and Crookes (2016) appeared disturbed by the large range of clinical skills that were taught by Australian HEPs. In this current study, the participants were focussed on the skills of clinical reasoning and decision making, coordination and provision of care and communication skills. These assessments included similar areas to those identified by Gregory et al. (2008).

Gregory et al. (2008) identified students commonly failed through unsafe medication administration, inadequate or inappropriate skill application, incorrect reporting and inadequate recording of information about vital signs (not knowing the norms), chest pain (a lack of critical thinking) and patient discharge (Gregory et al., 2008). Unlike Gregory et al. (2008) the participants in the current study identified that students must know how to access and utilise resources such as the Monthly Index of Medical Specialities (MIMS), handover acronyms, abbreviations and timelines for providing care.

Levett-Jones et al. (2017) and Skingley et al. (2007) recognised that student practice should be safe. At times, assessors use their intuitive judgement to assess safe practice (Skingley et al., 2007). This current study similarly found that the ‘bottom line’ for readiness was safe practice.

Hunt et al. (2016b) conducted a study in the USA to explore mentors’ perceptions about what enabled them to decide to fail students. The authors found the decision to pass or fail a student was based on either the student’s performance, the mentor’s performance or the university’s response. Hunt et al. (2016b) recommended that further research occur on the ‘gist’ of underperformance, appeals and failing students. Similarly, in this study, participants found they were asking questions related to the student’s performance.

To make decisions about student safety and competency, participants in the current study asked the same question that had arisen in Hunt et al.’s (2016b) study: ‘Would I let this student look after me?’. However, most participants in the current study did not ask the question, ‘Who has failed—the student or me?’. Instead, participants asked, ‘Am I doing it right?’. This question was related to the whole experience of facilitation rather than just that of failing a student. Although Hunt et al.’s (2016b) process for decision making included the question, ‘Will my decision be valued?’, the CFs in this study gathered evidence, felt convinced in their decision and (at times) discussed these issues with HEP faculty members.

Hunt et al. (2016b) further identified four needs of mentors: emotional support; appraisal support such as feedback and affirmation; instrumental support such as time and resources; and informational support to guide the supervisor to navigate decision

making. Broadbent et al. (2014) identified a lack of time for preceptors to perform their role in supervising students. In the current study, most participants reported the same, including the lack of time and availability of resources. They had felt that their hand were tied.

Woods et al. (2015) explored the confidence level of students after completing a capstone unit. The authors recognised that students were still underprepared and concluded that a student's high level of confidence in completing tasks did not mean that they could competently provide care. The current study attempted to understand how HSS gave opportunities for students to decide on care for patients that were likely to increase the students' level of confidence. The participants reported that students were not familiar with the decision making and responsibility necessary for the role of the RN.

Although participants wanted opportunities for students, students struggled consistently to access them. Having the opportunity to manage the care of a patient load of two may mean that the student could be signed off as independent, but this did not match the reality of a four or six patient load. The other team members performed more complex tasks and left students doing basic tasks such as observations and showering of patients, which did not prepare them for making decisions about the total care needs of patients.

Although confidence is seen to equate to student readiness (Nash et al., 2009; Woods et al., 2015), the findings in the current study and that of Woods et al. (2015) show that the student's confidence did not appear to be a determination of readiness; instead, confidence was seen to mask unreadiness. The opportunities to practice total patient care of a group of patients as expected of the RN on a final placement did not match the care that they would need to provide as a beginning-level nurse.

In determining readiness, participants' experiences seemed to show a disparity between the achievement of independent practice and that of safe practice. Although the goal for students was to achieve independence, explicit comments about being safe and being ready with much support were made to indicate that their assessment of readiness did not always include the level of independence expected from the NCAS (Brown & Crookes, 2016b). The new standards stated that 'RNs are responsible for

autonomous practice within dynamic systems' (NMBA, 2016, p. 1), with a focus on the safeness of care in collaboration with other healthcare professionals.

Wolff et al. (2010) saw a disconnect between expectations for readiness and the reality of the student's ability to be work ready. They shifted their thinking from 'ready to hit the ground running' (Wolff et al., 2010, p. 9) to global readiness with some competencies that were specific to the job. Global readiness meant that patients would receive safe care and new graduates would be able to adapt to healthcare and organisational changes (Wolff et al., 2010). The authors advocated for more knowledge about how readiness was defined, operationalised and measured.

In this study, it appeared that most participants had conflicting expectations about readiness. They acted to ensure that students could 'hit the ground running', but the reality was that students struggled to obtain opportunities to take on the full role and workload of an RN to consistently demonstrate that they could be independent in their nursing practice. Instead, there appeared to be greater consensus about the need for safe practice.

Haddad (2016) found differences between HEP faculty and HSP placement coordinators in expectations of readiness. BNPCs expected new graduands to 'hit the ground running' while NUMS expected new graduands not to be work ready for employment, but that they were on a journey of developing competence and would require time to develop full independence. Haddad's findings were corroborated by the current study, as students could not 'hit the floor running' but could practice safely. The 'second part' of their training would continue once they were employed.

Christensen et al. (2016) also reported that students who were not ready for the role of the RN felt like imposters. Once they became employed, their confidence was temporarily suppressed by the workload. The current study identified that the new graduate's practice was different from the reality of the workplace and that students on a final placement were not always given consistent opportunities to practice or carry out the workload of an RN. This finding supports that of Haddad (2016) on the disparate reality of practice before and after employment.

7.3.3 Managing Risks

The managing of risk occurred through the processes of developing a plan, acting and monitoring the outcome. Three concepts identified in the literature about the managing of risk factors concurred with the findings of this study: enhancing readiness; responding to obstacles related to resources; and responses to navigating current traffic conditions.

7.3.3.1 Factors Enhancing Readiness

Factors enhancing readiness in the literature were identified as best practices for the CLE developed by the Department of Health and Human Services (2016a). The Department of Human and Health Services (2016a) identified six key elements of BPCLEs: an organisational culture that values learning, best practice clinical practice, a positive learning environment, an effective health service–educator provider relationship, effective communication processes and appropriate resources and facilities. The participants in the current study identified these elements as enablers assisting them or students on the journey of developing students for the role of the RN. The most significant aspect of the CF’s toolbox was the valuing of the learner and the opportunity to extend student attainment to that of being a safe and independent practitioner.

Walker et al. (2015) described how they measured the factors or features of social intelligence, personal work characteristics, organisational acumen and work competence of new graduates for work readiness. Although they had compared the role of facilitation to the role of the preceptor, the work readiness scale appeared significant to understanding what type of assessments would include the features of work readiness.

In this study, the attributes of work readiness were evident through the comprehensive descriptions provided by participants. The feature of organisational acumen was seen throughout the provision and coordination of nursing care. Participants weighed up student maturity as that of being socially responsible and of having emotional maturity. Participants sought out the student’s professional work ethic and expected them to be self-directed and motivated.

In this study, the feature of social intelligence was seen throughout the assessment of how students communicated, comprehended and collaborated with patients and team members. Social intelligence features were also identified during the orientation period when participants understood the student's background, and on reading reflections written by students. The feature of personal work characteristics such as self-awareness, adaptability, flexibility, personal skills and self-direction was seen throughout the placement period and the striving to obtain learning opportunities. This study has added to this set of features characteristics such as being open and honest. The features of work competence such as clinical skills, critical thinking and problem-solving abilities were seen in the focussed assessments that participants had conducted. Having more life experiences was also likely to aid students in being ready to take up the responsibilities of the RN.

Helminen's (2017) study found that the final assessment of students would include orientation about the assessment process and the curriculum requirements; they would then practice and receive feedback about their performance. When the final assessment occurred, participants wanted students to be given a fair and consistent assessment. This was similar to Duffy's (2013) findings. Helminen (2017) identified that assessors conducted formal and summative assessments.

However, the findings of this current study were dissimilar in that the participants also had utilised informal assessments to focus on specific skills. The focussed assessments were similar to those reported by Brown and Crookes (2017) in that assessors had valued assessments of observing communication and nursing care skills, skills of good time management, prioritising of care, recognising deteriorating patients, utilising policies and other information and working within their scope of nursing practice. Although the scope of practice arose in this study, the participant's assessments of how students delegated care did not arise. Further exploration of how CFs assess the delegation of care is needed.

Brown and Crookes (2016b) sought nurses' perceptions about their expectations for student nurse competency and an independent level of practice. Brown and Crookes (2016b) found nurses considered that students could assess, plan, implement and evaluate care, and advocated for more connections between the skill sets taught and the development of competence in the clinical setting. However, these authors did not

describe the effect of a broad range of organisational factors that may have influenced student competency.

This study attempted to identify the assessment of clinical skills that CFs performed during a final placement. It identified how skills taught were connected to and developed in the workplace. In the current study the participants appeared to connect the skills, knowledge and attitudes necessary for a student in their final year through conducting focussed assessments, understanding how the resources provided by the HEP had matched up to the workplace and weighing up the confidence and readiness from the experiences of previously graduated students.

Craven's (2015) participants used the strategy of 'being objective' where they had sought additional feedback about poor performing students, documented behaviour and validated the reasons for student failure. In the current study, the participants recognised the value of documenting their dealings with struggling students. Also, similar to Craven's (2015) findings, participants were found to give students warning about—and ensured they had established evidence for—progression or failure. Unlike Craven's (2015) findings, the participants in this study had advocated for further interventions or recommended another placement or a passing grade when students were inappropriately or unfairly assessed by HSS. Participants also did not refer students to practice their skills in the laboratory setting of the HEP as the participants knew little about the process of remediation outside the health settings.

7.3.3.2 Responding to Obstacles Related to Resources

The literature identifies obstacles related to the provision and use of resources, which foreshadowed how the participants in this study responded. The provision of resources was associated with the availability of space and time to support students and the skills taught in the curriculum. The use of resources was associated with the scope of practice, safe practice and the assessment of skills and use of the LDP.

7.3.3.2.1 The Provision of Resources

The literature identifies that the provision of resources is associated with curriculum skills and expectations for students' scopes of nursing practice. Needham (2014) identified that the use of resources such as a supervisor's guide and HEP policies

related to the placement and networking was part of BPCF. Similar to Broadbent et al.'s (2014) findings, participants in this study raised their concerns about inadequate time to I, A & M risks. The resources lacking included space for privacy, the allocation of shifts, infrequent and short placements and a mismatch in resources.

Brown and Crookes (2016b) explored 30 clinical skills taught by HEPs. They concluded that students could be skilled in some but not all parts of providing care and that opportunities to perform all skills practised in the HEP setting had not been available during placements. However, these authors did not describe the influence of a broad range of organisational factors that may have influenced students' competency. The current study identified the assessment of a broader range of organisational factors that affected students' competency. Participants concluded that shorter shifts, evening shifts and infrequent and shortened placements could negatively affect how a student was able to adjust to the clinical area.

San Miguel and Rogan (2015) identified that students with a NESB could struggle; thus, they had developed a tool to assess English competency. Although the tool needed further refining, the authors concluded that this finding could stimulate further discussion and research. The current study found that most CFs did not utilise a specific tool to test English literacy and comprehension.

Although good communication skills are essential for all nursing students (Brown & Crookes, 2016b) only one participant reported on how a tool was used but found to be invaluable in assessing students' comprehension. Participants without this tool appeared to have more difficulty in understanding specifically how the student was comprehending notes, aspects of care, the handover and other communications by HSS. Participants recognised that they did not always have the appropriate tools or resources to notice or link the deficits in a student's practice. With or without these core skills, participants explained how they would navigate issues in the workplace and find ways to circumvent them.

Broadbent et al. (2014) reported that nursing supervisors were expected to be cognisant of curriculum requirements and the students' scope in performing nursing skills. The students' scope of practice required them to have direct supervision from an RN to oversee specific practices (Reid-Searl et al, 2010). Levett-Jones et al. (2017)

also expected that students understood the difference in the roles of nurses and their varying scopes of practice. Students working within their scope of practice were seen by participants to ensure the safety of patients (Levett-Jones et al., 2017). The scope of practice referred to the skills they had been taught and practised in the institution.

However, differing from these expectations, it appeared that students in the theatre setting were extended the opportunity to acquire new knowledge and practices to undertake their nursing duties. This extension of new theory and practice seemed contrary to the expectation that students would only partake in the skills that had been taught by the educational institution. This study also found that experienced ENs who were transitioning to the RN role were given opportunities to coordinate the ward with the ward coordinator. This experience was seen to assist them in expanding their ability to make decisions. Although contrary to the expectations of expanding their students' scope of practice, these practices appeared to be person centred where learning was tailored to the specific setting and the needs of the student.

Alderman (2017) discovered that meaningful workplace experiences extended students' feelings of being valued. These actions indicated that the CF had responded to the availability of resources and the opportunities to learn, which increased the practice readiness of students for specific settings and decision making. These findings also indicated that further research was necessary to clarify how other specialty areas utilise or expand the student's scope of practice when on a final placement. The current study found that participants sought to assess general readiness expected from the nurse, but more meaningful assessments were conducted by some participants who expected the students' knowledge and practice to match the specific skills and assessments needed in the clinical specialty.

A meaningful placement is expected to provide students with the practice and experience they need to consolidate their role as a nurse (Needham, 2014) and students were assessed on how they had provided safe patient care (Levett-Jones et al., 2017). Although Levett-Jones et al. (2017) expected safe practice to follow the use of evidence-based care, this study found that participants perceived that the use of best practice varied between health and educational providers. Students would be confused about what constituted best practice—their HEP training, health setting policy or the DOH's directives.

These situational variations appeared to arise from either an unavoidable delay in the flow of information, the timeliness of accreditation or a lack of communication between providers and individual nurses or nursing departments. It is a concern that these mismatches appeared to increase tensions between individual nurses and students in the workplace and had threatened the accurate assessment of student competency. As CFs updated students' knowledge, they were seen to bridge gaps in students' knowledge and practices.

Mismatches were found in Zilembo and Monterosso's (2008) study, but these were related to the obstructive mismatches of students with preceptors. This study extends mismatches to that in resources and appears to validate the findings of Calleja, Harvey, Fox and Carmichael (2016) who recommended that shared understandings are essential. Others also recommended that effective collaboration and communication was essential between providers and individual nurses to effectively support students (Budden et al., 2015; Lawrence, 2014; Russell, 2013; WHO, 2016).

7.3.3.2.2 The Use of Resources

Various authors have suggested using guidelines to assist with the identifying, assess and managing of student risks and progression (Coyne & Needham, 2012; Skingley et al., 2007). Coyne and Needham (2012) provided insight into the need for CFs to have pre-briefing guidelines for students in specialty areas. Participants did not specify that they had utilised specific guidelines, but they had used individual processes for orientating students, conducting student assessments, and were confident in using the RN Standards to assess student competency. Some participants matched learning to specialty areas but did not utilise specific guidelines set out for the specialty area.

Skingley et al. (2007) produced a guideline for practice teachers to manage risk outlining steps of having early discussions with students, communicating with lecturers, documenting and formulating a learning contract with the student and involving health setting managers if needed. The current study identified how participants worked alongside providers and individuals in a shared context to manage issues. The shared context in the current study is reported below alongside Gregory et al.'s (2008) findings.

Gregory et al. (2008) focussed on factors that influenced the identification, assessment and management of risk and saw the need to protect patients from errors and adverse events occurring from education and practice systems. Gregory et al. (2008) identified that LDPs considered areas for remediation that were related to professional/socialisation issues, nursing care concerns and clinical transgressions. The process also included documenting the steps to take for remediation, the clinical expectations and what the learning outcome was. Although the participants in this study did not outline what was in the LDP, it appeared that the shared context of dealing with issues was complex.

Terry (2013) reported that nurses used their wisdom to make decisions about how students had met the RN Standards. Likewise, some participants in the current study used their wisdom in not utilising a formal LDP with struggling students. Participants would turn towards using the formal LDP if they saw it was beneficial to managing the risks. Other participants turned away from using formal LDPs when they disagreed with HSS that students were struggling, when speaking to students informally about their practice (Duffy, 2013) or when the participant thought the student would be unfairly dealt with and traumatised by the approaches used by the HEP. The findings of this study built on Gregory et al.'s (2008) findings where the CI model, the clinical setting and the lack of preparation for practice were factors associated with students' unsafe practice. This study adds that the mismatch between a provider's resources and use of assessment tools can influence how students are perceived as struggling.

Processes for placing students on a LDP meant that participants weighed the reports they obtained from HSS against what they had themselves observed. Helminen (2017) found that the final assessment of students would include orientation about the assessment process and the curriculum requirements. They would then practice and receive feedback about their performance. This study had similar findings. Moreover, when the final assessment occurred, participants wanted students to have a 'fair' assessment. If the reported deficits of the student were not substantiated, the participants would seek out information as to why reports were contradictory. When participants had received contrary reports, they would re-evaluate the student to ensure that they had not missed anything. Then, similar to Needham et al.'s (2016) findings,

most participants would confirm with the HEPs and their facilitator colleagues the stance or actions that they should take.

Participants turned towards trusting their assessment of the student in a situation where HSS were hostile or biased, or the student had not been given opportunities to develop. For participants relying on others to undertake the I, A & M of students' risk, there did not seem to be any disagreements about the assessments of student progress and readiness. However, doubt about the readiness or ability of students was raised when participants perceived that students in specialty areas might find it challenging to meet the learning objectives that the HEP expected from them. Participants did not report on managing students with a LDP when they were relying on HSS to I, A & M risks for readiness.

Similar to Gregory et al.'s (2008) findings, the participants in the current study identified that the implementation of a LDP would threaten students. Similar to Duffy's (2003) findings, students were given another chance to improve on their nursing practice. Participants reported that when students were struggling or feeling threatened by failure, participants and HSS at times had experienced intimidation from students. Contrary to the participants in Gregory et al.'s study, those in the current study did not appear to be swayed by such intimidation and did not change their assessments. If students were struggling, they were given a LDP or a reprimand. In the current study, the giving of a LDP was at the discretion of the faculty, the CS or a cooperative process between HSS or faculty members such as the unit coordinator.

In contrast to Craven's (2015) findings of remediation, the participants in the current study knew little about how the remediation process occurred after students had been removed from the placement. Likely this was related to the short turnaround of placements and the likelihood that the identification of the issue was not timely enough. Although some participants said students had another chance, it was not in the same period the student had undertaken the placement. More information about the remediation of students would benefit CFs who must supervise students on a repeating final placement.

Gregory et al. (2008) outlined expectations for preceptors to liaise with students at the end of the shift and the designated CF at the end of the placement period. A surprise

in this study was the directive of some HEPs to not disclose a student's LDP to the preceptor or buddy nurses. As the LDP is intended to assist and support students, some participants expected that the old ways of sharing and discussing LDPs with relevant HSS would enable focussed direction for developing the student's nursing skills and would focus directly on how support should be given to the student by HSS and the CF. Also, managing the risk in this shared context would enable better monitoring of the student's progress.

The nature of a fragmented workplace is likely to make it difficult to monitor or obtain written evidence about a student's progress. Moreover, the participants and buddy nurses who did not know the objectives of the LDP were not able to assist the student in bridging their deficits. CFs were conflicted as their authentic expectation for openness and safety was expected to have a lower priority than that of student confidentiality. Participants feeling this way felt the need to first consider patient safety. Participants who accepted it was the student's responsibility to disclose this information did not appear to have internal conflict. Confidentiality was the overarching boundary for whether to disclose or not disclose the contents of the LDP. The HEP expected that students were adult learners and that adult learners are self-directed and motivated to achieve their learning needs.

The issue of confidentiality in supervising students appears to be an area that needs further investigation. As health setting workplaces may be fragmented and the supervision of students is transient, it seems that disclosure of struggling students will be necessary for patient safety and the monitoring and management of risk, or the removal and failing of unsafe students. Similar to Duffy's (2013) findings, debriefing the CFs and the CS about their experiences appears to be necessary to improve the processes of dealing with risk in the workplace. Moreover, how external providers engage, communicate and demonstrate accountability to the HSP about student risks is likely to be essential for the HSP to identify, prioritise and manage risks (WA DOH, 2016). Once risks have been managed readiness can then be determined.

The next section deals with the findings related to the participants' responses to navigating the CLE. These responses were separated from navigating the obstacles, as they affected how the participants perceived they were powerless or were enabled to

add tools to their toolbox and manage the barriers or risk to student readiness. These findings are now compared with those in the literature.

7.3.4 Responses to Navigating Current Traffic Conditions

Needham (2014) identified that the use of resources such as a supervisor's guide, HEP policies and networking was part of having BPCF. HWA (2010) considered that all supervisors and facilitators had to assist the student in bridging the gap between their theory and their practice. Needham (2014) recommended that BPCF was learning to effectively facilitate, along with actions of interacting and communicating effectively, being supported and using exemplars of best teaching practice. Although Needham (2014) did not outline the evaluation of the CF's support as best practice, the participants in this study wanted to receive an evaluation from either the students or the HEP.

Mackay et al. (2014) in Queensland conducted a participatory action research study to identify how best to support CFs using a professional development workshop. According to Mackay et al. (2014), this program showed there were aspects of the partnership model that were led by the academic team and those led by the facilitator in partnership with the academic team. Sharing responsibility for students' practice and supervision was recognised by other authors (Killam et al., 2012; McInnes et al., 2015; Skingley et al., 2007).

This study identified how CFs, HSS and providers can partner in the assessment process or have shared understandings. Although the HEPs had received feedback from students about their facilitators, the participants were not given this information. The participants needed this information to see where they were succeeding or failing to support students. It appears that as this knowledge was not exchanged with participants, a shared or partnering process did not occur.

In response to navigating current traffic conditions, the current study describes that the degree to which CFs connect with groups and individuals within the organisation is one where participants attempt to bridge varying expectations, feedback, the use of resources, variances in specialties and the working relationships of providers and individuals. It is also that of straddling where participants felt insecure, experienced

doubt or felt wary about the identification, assessment and management of risk and desired the opportunity to contribute to facilitation processes or personal change.

Needham (2014) reported that CFs feeling alone or isolated was not a new finding, and there were similar findings in this study, including CFs questioning whether they were 'doing it right'; feeling that 'their hands were tied' by the factors related to resources, supervision and relationships; and 'keeping quiet' about issues they experienced to protect relationships between HEPs and HSPs. These feelings demonstrate the tenuousness of relationships and the need for evaluation, support, debriefing, training and processes. Further, they highlight that further connections and opportunities were needed for the CF to develop and solve problems collaboratively with providers and individuals. CFs without support are interpreted as having 'a cloud of doubt' surround them when trying to make the right decision to solve issues about student competency.

Participants who did not feel alone did not question if they were doing it right, did not keep quiet about issues or found ways around the barriers they experienced. These participants seemed to bridge the divide by networking with their colleagues or using strategies to obtain feedback and to manage other issues in the workplace. Most participants appeared to connect with and work within the professional boundaries expected by the participating organisations. However, the varying ways that HEPs might expect the CF to handle issues did not arise as a factor of risk when using networking to solve issues related to student risks. Participants who wanted to know if they were doing it right developed questionnaires for students to complete or had evidence in the form of students providing them with cards of appreciation. Participants who did not keep quiet about the issues they saw had focussed on safety and a vision for improving the quality of nursing care. In contrast, participants who did keep quiet did so because of the perception of a lack of interest from the providers, or to protect tenuous relationships between providers.

Russell (2013) developed and implemented the Art of Clinical Supervision Program for Registered Nurses to guide RNs in the supervisory role. Although this program was being implemented prior to the current study and was perceived as providing valuable education, some participants were only just planning to attend the new

program. This indicates that further exploration should be conducted into why participants did not take up available training when it was offered.

The next section of this chapter compares this study's finding with the relevant theoretical perspectives outlined in Chapter 2. This is with a view to examine the current findings with existing theories to add to knowledge of the phenomenon. The chosen theories explain the journey of the participant in this study who supports students on a final placement.

7.4 Comparison of Findings with Theories

Five theories were chosen for this study as they are relevant to the investigation of the lived experience of CFs. These theories explain the phenomenon of the lived experience of the participants and were discussed in Chapter 2. They are the General Systems Theory (Katz and Kahn, 1978), Heron's Facilitation Theory (Heron, 1999), Bloom's Taxonomy (Henry & Murry, 2018), the risk management approach (WA DOH, 2016) and the Ascent to Competency model (Levett-Jones, 2007). These models were introduced and discussed in Chapter 2.

7.4.1 General Systems Theory

The nature of General Systems Theory is one of interaction between the parts of the system and the external environment (Von Bertalanffy, 1968). This theory was chosen for this study as the CF must manage the interaction processes using systems, guidelines, requirements and processes from the external environment of the HEP, the HSP and regulatory bodies, along with the expectations and attributes of other individuals. The quality of the interaction the CF has with the internal processing of inputs influences the outputs, which in this study referred to the effective identification, assessment and management of risk for the practice readiness of students.

Within the boundary of a CF's system, they will receive and provide feedback about the process of inputs, throughputs and outputs. The interaction with the environment and the experience undertaken will include feedback to and from the external environment. The concepts related to this study are shown under each part of the system in blueprint. It is for these reasons that this theory is relevant to this study.

The current study explains how the Open Systems Model adapted for clinical facilitation worked with and utilised the external environment within the boundaries of organisations and individuals. The blue segmented line in Katz and Kahn’s (1978) Open Systems Model as adapted and illustrated in Figure 101 shows how the current system did not adequately utilise feedback to and from the external environments to improve throughput. The thickness of the lines in the systems model of clinical facilitation demonstrates the significance of feedback to enable effective change.

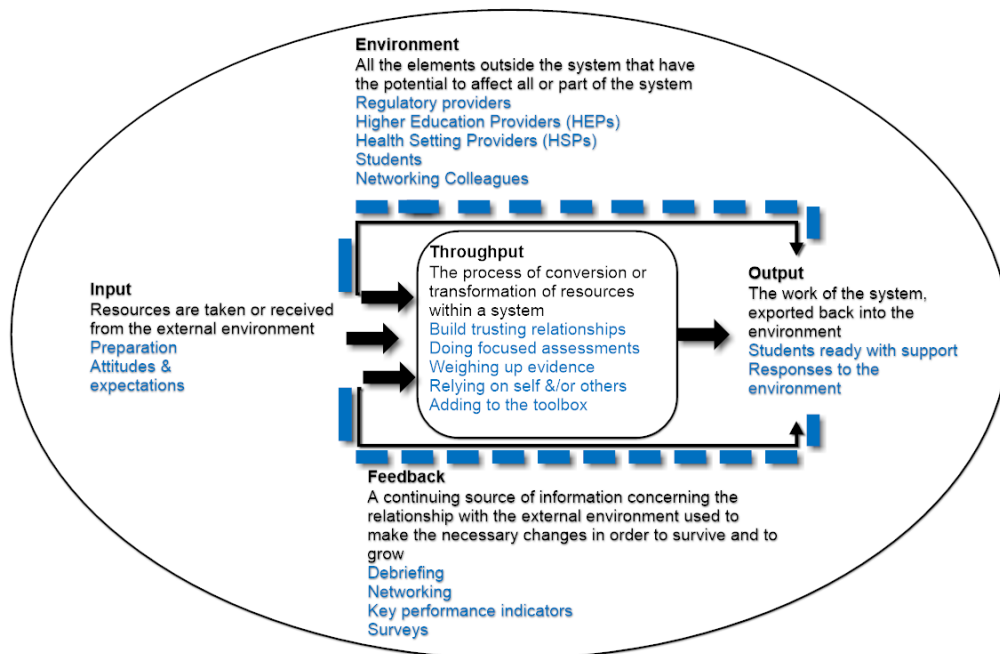


Figure 101: Katz and Kahn’s (1978) Open Systems Model adapted for clinical facilitation (CC-BY Creative Commons Licence)

This study found that CFs did not have control of the external environment: the structure of placements, the resources or the culture of the workplace. As mentioned by Ramosaj and Berisha (2014), the individual is not able to take control of the external environment, but must respond to it. Experienced participants in this study who were not dependent on the liaison role responded to the external environment by relying more on themselves to build trusting relationships, weigh up evidence and learn from their experiences to improve inputs and outputs. Students were part of the external environment by providing feedback to a small proportion of participants.

The participants who took an active role in the identification, assessment and management of risk received some feedback from students to transform how they

supported them on a final placement. However, this transformation occurred without sufficient input from the HEP. The questions that participants continued to ask demonstrated that they were unsure of how they met the expectations of providers for best practice in clinical facilitation.

The next section expands the role of Facilitation Theory. This theory provides further information on how the identification, assessment and management occurred with or without input from the HEP, HSS, a network of colleagues and students.

7.4.2 Facilitation Theory

Heron (1999) described Facilitation Theory as relating to managing the six dimensions of facilitation: planning, meaning, confronting, feeling, structuring and valuing. These dimensions occur in three ways and determine how decisions are made on each dimension (see Figure 102). The hierarchy mode, the cooperative mode and the autonomous mode describe who controls the decisions (Heron, 1999). This model was chosen for this study as it provides a way to explain how CFs would make decisions and manage students in a shared context with HSS, students and faculty.

Heron's (1999) adapted dimensions and the modes of Facilitation Theory explain the hierarchy mode where the CFs valued control and took control of the planning and orientation processes. The cooperative mode explains how the CFs relied not only on their own identification, assessment and management of student risk but also on those of others for this process. In the autonomy mode, the planning dimension was left up to others such as HSS, the student or HEP faculty. These descriptors are shown in blue text, and the findings of each dimension and mode are illustrated in Figure 102 as blue-shaded boxes.

Dimensions & Modes of Facilitation Theory	Planning Dimension	Meaning Dimension	Confronting Dimension	Feeling Dimension	Structuring Dimension	Valuing Dimension
	<i>How shall the group acquire its objectives?</i>	<i>How is meaning given or found in the experiences and actions of group members?</i>	<i>How can the group become aware of issues and deal with them?</i>	<i>How should group members feelings and emotions be handled?</i>	<i>How can learning be best structured?</i>	<i>How can a climate of personal value, integrity and respect be developed?</i>
Hierarchy Mode <i>The facilitator alone makes the decisions. Much direction is needed for learners or group members.</i>	Preparation Planning Orientation	Making sense by relying on self for the identifying, assessing and managing of risk and readiness Weighing up the feedback	Undertake focused assessments Turn toward or away from the LDP	Being reflexive Being open and visible Being trustworthy	The CF utilizes orientation processes, tools, and strategies to identify, assess and manage student learning	Do focussed assessments Use values of transparency Conduct fair assessments
Cooperation Mode <i>The members have some control over the decisions with the facilitator Learning is guided</i>	Members plan in context of students learning objectives, their scope of practice, their strengths and weaknesses, other needs, and specialty expectations	Seeing or not seeing deficits by relying on self and others for the identifying, assessing and managing of risk and readiness	Responding to obstacles related to people and resources LDP is shared Managing conflicting opinions Formal and Informal Assessments	Giving & receiving of feedback through Networking, formal meetings, and debriefing opportunities	Obtain and share feedback Learning needs and opportunities to practice are provided by all RNs	Turning towards managers Building trusting relationships through familiarity
Autonomy Mode <i>The facilitator does not have any control over the learner or group decisions. Self directed members</i>	Providers determine the contexts and the objectives CS delegate practice opportunities to students	Making sense of situations is done by others in the identifying, assessing and managing of risk & readiness	LDP developed, implemented and monitored by others LDP is shared only at the discretion of the student	HSS or HEP control process of debriefing with students	HEP, HSP and/or students control the learning objectives, feedback and opportunities to develop	Having to trust others for the development of individual needs

Figure 102: Heron’s (1999) adapted dimensions and modes of Facilitation Theory (Permission obtained)

As a result of this study's findings, the original model has been adapted to include the descriptors. An interesting finding here is that a combination of Heron's modes could produce tensions and conflicts for CFs in the management of risk. In the cooperative mode, students who struggled had received a LDP. This plan was developed, implemented, shared and monitored with HSS. However, in all three modes, the plan may be developed by an individual or with the HEP but may not be shared. Instead, both the management of the student's risk to practice and their learning opportunities were left up to the discretion of the student. Additionally, although the liaison role appeared to suit the cooperative mode of facilitation as it makes possible a closer working relationship between people and organisations, the liaison facilitator may not see deficits if they have not assessed the student and HSS are too inexperienced to see them. This action then places the CF in the autonomous mode where they are relying on others to I, A & M risks.

7.4.3 Bloom's Taxonomy

The process of learning occurs in practice where the accumulation of experiences is used to recall, inform and refine an individual's practices and motivations (Henry & Murry, 2018) and to lead them towards greater competency. Bloom's three domains of learning explain how students are assessed. These domains consist of cognitive (knowledge), affective (attitude) and psychomotor (physical) skills (Bloom et al., 1956). Henry and Murry's (2018) illustration of these domains provides a clear depiction of the overlap of the domains. The overlap illustrates how the assessment of safe practice would incorporate individual domains of Bloom's Taxonomy or a combination of them. An adaptation of the three domains of Bloom's Taxonomy (Henry & Murry, 2018) is illustrated in Figure 103.



Figure 103: Readiness for practice (Adapted from Henry & Murry, 2018, Figure 1, p.268) (CC-By Creative Commons Licence)

This study has contributed to the literature and explains Bloom's Taxonomy as the assessment and attainment of safe practice in the learning domains of cognitive, affective and psychomotor skills. As the objective of this assessment is to have students ready for practice, the process of assessing the cognitive, affective and psychomotor domains of learning overlap and occurs throughout the placement period. In being ready for practice, students will have demonstrated that they are safe practitioners who need further support to become autonomous practising nurses.

In the first domain of cognitive learning, CFs assessed students' knowledge including of terminology, the ability to recall information and the ability to state principles that guide nursing practice. In the second domain of affective learning, CFs evaluated the attitudes of students by noticing how they had responded in the workplace. In the third domain, CFs were expected to evaluate the psychomotor or physical skills of students. Participants in this study mainly focussed on medication skills. HEPs expected CFs to undertake specific skill evaluations as part of informal and formal processes, but participants in this study conducted additional assessments that focussed on specific skills outside of formal assessments. In this study, it was found that unless a participant practised each shift with students on a final placement, psychomotor skills appeared to be predominantly assessed by HSS. The process of managing risk in this study is now described using the DOH's (2016) approach to risk.

7.4.4 The Risk Management Approach

In WA, the process outlined to manage risk in clinical settings occurs in five steps: establish the context, identify risks, analyse risks, evaluate risks and treat risks (WA DOH, 2016). These steps are relevant to all healthcare professionals. Individuals and organisations are expected to be transparent and accountable in how they I, A & M issues about the likelihood of risk and its potential effects (WA DOH, 2016).

The process of managing risk is not only a stepped-out process, but can also occur in a non-linear way. To represent differences, the blue arrows in Figure 104 show the additional interconnections between the steps of communicating and monitoring risk in the context and treatment of risk. The risk assessment extends to the step of 'Establish the context' and the treatment of risk related to these steps needs further reviewing and monitoring. The WA DOH model has been adapted in Figure 104 to show the variation in how the CFs managed risk in the health setting.

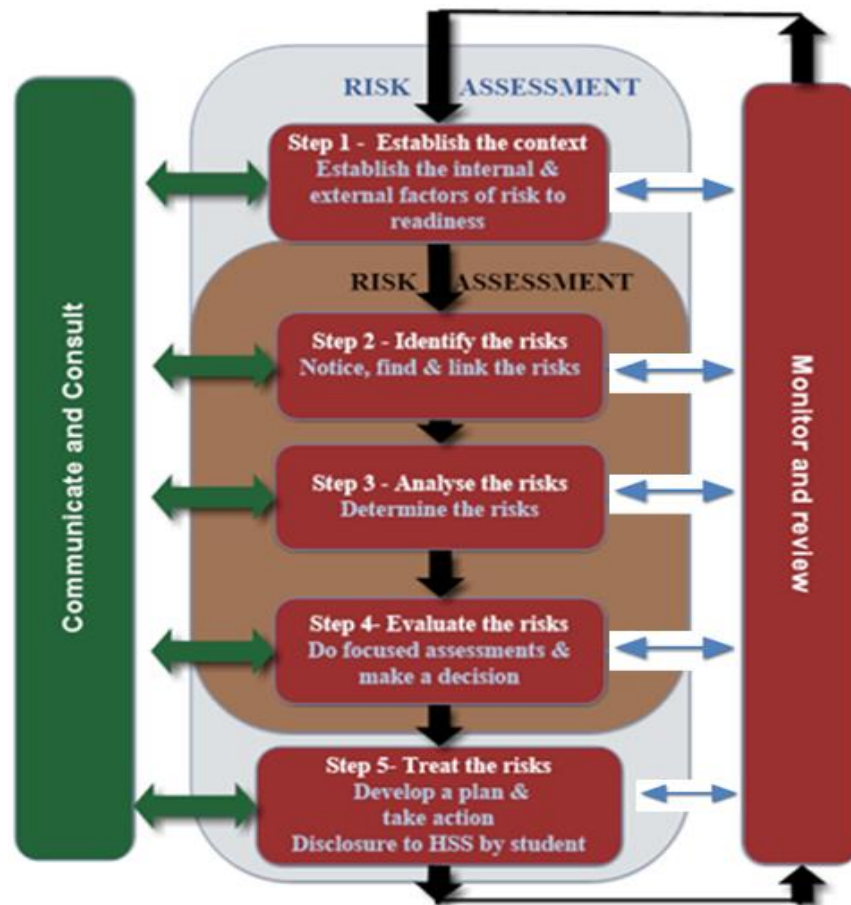


Figure 104: The risk management process for student readiness (Adapted from WA DOH, 2016). (Copyright to this material is vested in the State of Western Australia unless otherwise indicated)

The CF is expected to be transparent and accountable in how they I, A & M the likelihood of risk (DOH, 2016). Although the current study did not measure likelihood, participants identified the factors that were likely to increase the risk to patients and an individual’s safety. This study identified that the CF manages risk not only for student readiness, but for the safety of patients and other individuals, for the reputation of the HEP and for being accountable to the HSS and the HEP. The risks involved both strategic and operational functions. The next section outlines how risks to readiness occur, through the Ascent to Competence model.

7.4.5 The Ascent to Competence Conceptual Framework

The Ascent to Competence conceptual framework developed by Levett-Jones (2007) incorporated an adaptation of Maslow’s (1943) Hierarchy of Needs. Levett-Jones’s (2007) model explained how various factors affected the motivation of students to

become competent beginning-level nurses. The authors ranked first the need for safety and security, followed by belongingness, self-concept, learning and competence.

The Ascent to Competence conceptual framework (Levett-Jones, 2007) (Figure 16) was adapted to include this study's findings in the sections of the organisation, contextual, interpersonal, individual and the hierarchy to competence (see Figure 16). The circular lines are segmented to show that these factors interrelate and can influence each other; as such, organisational factors will influence individual CFs in how they turn towards or away from authentic behaviour and providers' expectations in support of students. Moreover, these factors will influence how CFs use facilitation styles to rely on themselves or others to manage student readiness. The new concepts added to the Ascent to Competence conceptual framework include individual, interpersonal contextual and organisational factors (blue boxes) (see Figure 105).

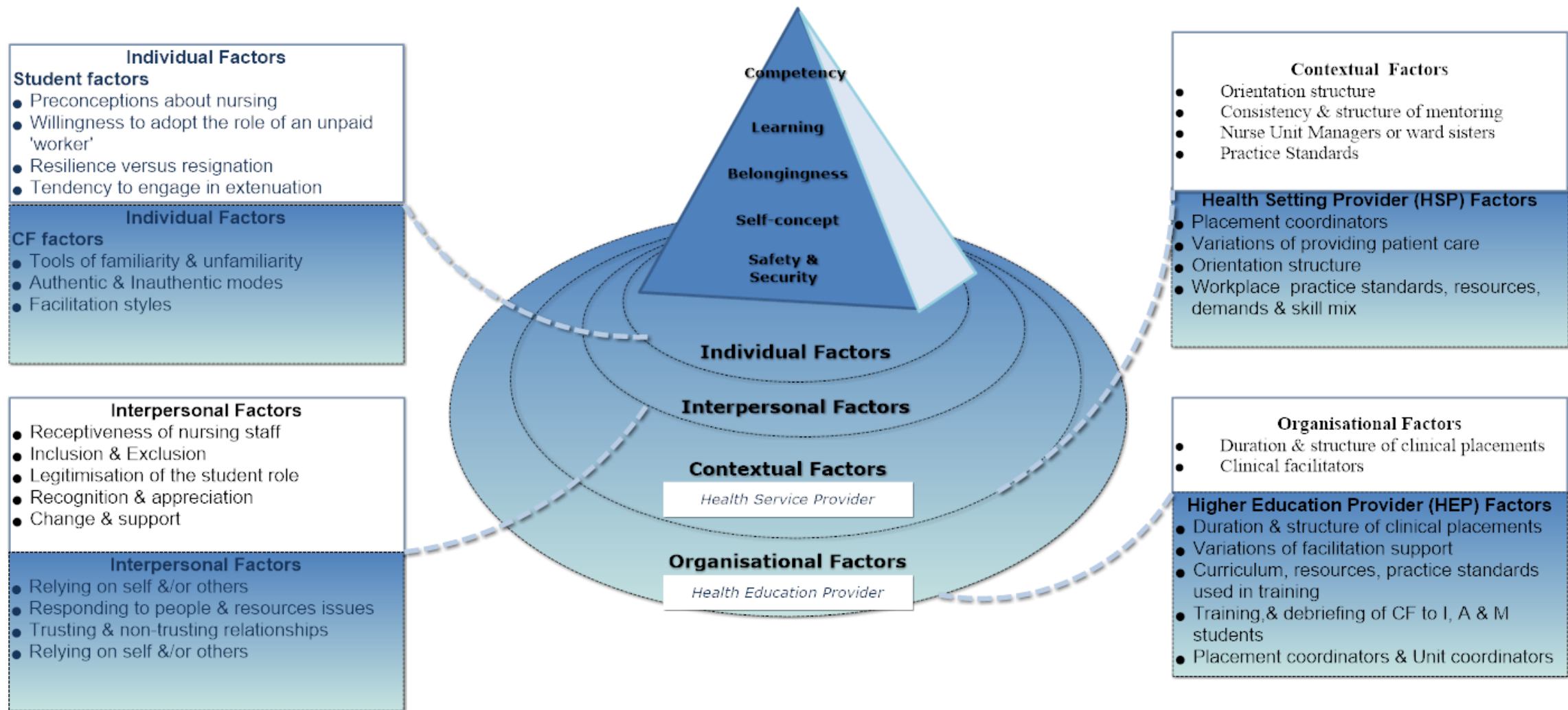


Figure 105: The Ascent to Competence conceptual framework adapted for CF competence (Permission obtained)

The current study identified similar themes of belongingness that were related to the organisation, contextual, interpersonal and individual factors that may aid or hinder the CF in motivating and supporting student readiness and competency for the role of the RN. Similar to students, CFs were able to support students better in safe environments where their values and the values of HSS resulted in effective modelling of behaviour. CFs also wanted to be recognised and respected for their contribution to students and needed opportunities to debrief and develop their knowledge and skills. Once these basic needs could be met, participants would feel more competent and confident to address the issues students faced.

7.5 Salient Outcomes of this Research

The purpose of this study was to explore the lived experience of CFs through in-depth interviews to determine how they identified, assessed and managed factors of risk to the readiness of students who were on a final placement. Interpretations followed a Heideggerian phenomenological approach (Conroy, 2003). It was anticipated that this study would provide insight into the complexities of assisting nursing students to be ready for professional practice and nursing registration. In-depth interviews were conducted in the Western Australian context.

A cloud map of narratives and interpretations from the findings was created to show the major words utilised by the participants and the researcher in the findings chapters: Chapter 4, 5 & 6. The major words that emerged from the findings section were participants, supports, students and clinical (see Figure 106).

values, clinical and academic experience, familiarity with individuals and resources, and the ability to develop and use tools and be resourceful. None of these attributes was unique to this study, but the collection of attributes in this study are interpreted as significant factors that enabled or hindered the CF in the identification, assessment and management of risks.

However, a lack of debriefing opportunities meant participants had to rely on other colleagues for practical suggestions about managing issues. Literature findings on networking had not recognised the potential crossing of boundaries between individual organisations and indicated the need for further research and discussion. Processes were needed to manage the debriefing of CFs, the giving of feedback and the access to networks, and to enable support for CFs and students across HEP boundaries.

7.5.1.2 Research Question 2

The second question focussed on how CFs identified, assessed and managed the factors that hindered students on a final placement in becoming ready for the role of the RN. The identification, assessment and management of risk was conceptualised as a cycle and was developed to assist with the process of managing the risk. This cycle is unique to this study.

The participants' descriptions showed that the parts of the cycle could occur in any order. In dealing with people and resources, participants relied on themselves and/or others to I, A & M risks. The level of experience and familiarity with processes resources and relationships of HEPs, HSPs and HSS influenced the level of reliance on themselves and/or on others. The liaison role relied more on other nurses to I, A & M risk to student readiness.

As experienced academics, clinicians or facilitators, participants conducted additional focussed assessments, expanded the student's knowledge and practice and used strategies to obtain and weigh up the reliability of feedback. When disputes arose about competency, CFs would reinvestigate and re-assess students. The outcome was that they obtained evidence and increased reliance on their personal assessments on student competency.

In contrast, participants inexperienced in academia, clinical specialties, facilitation or the liaison role relied more on others to I, A & M risks. Unless the participant was able to undertake additional assessments, they were prevented from observing deficits and needed to trust more in the assessments made by CSs or other HSS. This finding showed that students may have passed who were not ready, and unless the CF was able to identify how transient or unwelcoming relationships and resources affected student development, the student might be threatened with failure. The best approach to supporting students was to have the CF become familiar with academic, specialty and facilitator expertise to I, A & M the risks associated with the structures and resources, and with nurses and students. The use of the CF's toolbox emerged as a distinct finding from this study.

Another significant finding in this study was the response of participants to how they managed to I, A & M risk to student readiness. Some participants felt alone and some questioned whether they were 'doing it right'. Some felt that their 'hands were tied' or they kept quiet about issues to protect the relationship between providers. However, these feelings and questions highlight that further connections and opportunities were needed for CF's to debrief, resolve and develop esteem and confidence in the role.

A surprise in this study was the mismatch in resources between HSPs and HEPs. Best practice either had not yet been adopted by HSS or had not been taught to students. The mismatch in the use of best practice meant that students may at times be denied or given the opportunity by HSS to use the most recent evidence.

When using resources such as the LDP, CFs turned away or towards using it based on the prioritisation of values regarding the benefits of the plan or the resultant effect on students. The monitoring of the LDP caused participants to experience moral conflict for other's safety when they could not disclose this plan to HSS. Non-disclosure conflicted with some participants' values of being open about the risks and learning needs of students. However, participants recognised that the disclosure of the LDP was in the student's toolbox, not the CF's. Further dialogue about empowering students to share this plan and have HSS support them is necessary for monitoring the risks and the progress of a struggling student.

Most of the participants in this study worked on the basis, often expressly stated, that their understanding of 'readiness' was the student's ability to step into employment and practice independently; however some of the participants believed this to be unachievable. Although the participants had facilitated with the intention of getting students to an independent level of practice, the reality was that students would pass if they had a general level of readiness; that is, if the student was safe to undertake care with support. This finding implies that the current nurse training program does not make students ready for independent practice. Instead, students who are seen to meet the RN Standards with respect to safety and with the appropriate attitudes are fit to pass. Ideally, once registered, these new nurses will then move into a supportive transition program. It is this practice that then makes them ready to take up the role of an independent practitioner.

The next section outlines the strengths and limitations of the study.

7.5.2 Strengths and Limitations of the Study

All studies are likely to have strengths and limitations. Pringle et al. (2011) asserted that researchers who used IPA would be able to assist nurse researchers to listen to and understand participants. My previous experiences of clinical facilitation were central to making the connections between what was said and what was meant about the participants' experiences. The use of IPA tools using Heidegger's central tenets as compiled by Conroy (2003) kept a focus on the participants' experiences. The insight of the study supervisors ensured that the interpretations were trustworthy. Although participants' experiences varied, the range of experiences often overlapped. The IPA methodology was a strength of this inquiry, which thus adds to the greater body of knowledge about how CFs deal with risk on final placements.

The main limitation of this study was that it was conducted only in the state of WA and only in the Perth metropolitan area. The sample of CFs was purposively selected from the population of CFs in WA as homogeneity was necessary to address specific questions posed in a qualitative study (Grbich, 1999; Smith & Osborn, 2007). Although including other contexts may not necessarily change the overarching themes of a study, this study occurred during a time of rapid expansions occurring in the WA health setting: new hospitals were being built, staff were unsure about the continuation

of their employment and experienced international nurses were being recruited to staff health settings.

A further limitation was not interviewing CFs who were seconded from the health settings. As HSS are likely to know more about the adoption of practices in their setting, they may have provided additional information about the facilitation processes they had used. These processes of identification, assessment and management of risk as described in this study may have been different for CFs associated clinically with the health setting.

7.6 Chapter Summary

This chapter has discussed the study findings in the context of the current literature on the factors that hinder the identification, assessment and management of risk to student readiness. It has also compared the findings of this study to five theories that can explain the lived experience of the CF. The lived experiences were explained from the perspective of the General Systems Theory, Facilitation Theory, Bloom's Taxonomy, risk management approach and Ascent to Competence model. Further, the strengths and limitations of the study were discussed. The next chapter discusses the implications and recommendations arising from these findings.

Chapter 8: Implications and Recommendations for Practice

Collaborative resources and relationships are needed to support not only CFs but also the CSs who bridge the theory–practice divide. Of highest importance, the development of relationships and additional collaborative resources is crucial to the student’s ability to take up opportunities for practice and support during a final placement. This study concluded that students can be assessed as safe to practice but may not be autonomous practitioners upon registration without support. This finding has implications for HEPs who expect that on a final placement, students will function at an independent level with minimal cues.

8.1 Implications

The sustainability of the CF role appears essential to the identification, assessment and management of student issues. These findings suggest that facilitators need innovative ways or processes that will support them individually and collectively in their role of preparing students to enter the workforce. Additionally, and separate to the topic of interest, the research methodology has implications for other researchers who may wish to utilise an interpretative approach methodology to explore phenomena.

At the individual level, this study identified how the participating CFs performed their role in providing learning opportunities and identification, assessment and management of risks to student learning. The findings provide insight into how CFs may feel alone and underutilised to enact change for improved outcomes, not only for themselves, but for their students and for the organisations that they support.

At the organisational level, the findings of this study inform providers about the nature of collaborative partnering in the identification, assessment and management of risk to graduate readiness. In particular, the increasing number of international nurses who are unfamiliar with local systems and the shortage of dedicated supervisors for students requires new ways of thinking. The transient nature of the workplace and mismatch in resources highlights the need for new approaches that enable the building of trust for students to practice the RN role. This study also has implications for improving workplace culture. At a societal level, the adoption of innovative ways to utilise technology and incorporate processes to be cooperative in the identification,

assessment and management of risk is likely to produce a more sustainable and cohesive working environment.

The results of this study also indicate that Conroy's interpretative approach has been beneficial for understanding the phenomenon of how CFs I, A & M risk. The use of the Heideggerian principles for research, and the hermeneutical commentary will assist new researchers using the interpretative methodology in their qualitative research. This study provides for future researchers a reference that can support them in staying true to the Heideggerian approach.

8.2 Recommendations

This research outlined several areas in which the relationships between nursing staff, CFs, providers and students could be better supported. Recommendations support better use of technology and resources that will nurture and sustain relationships. Additionally, research recommendations are provided so that a greater understanding of the varying contexts and needs of CFs can be developed.

8.2.1 Recommendation 1: For Providers

HEPs and HSPs utilise approaches that best support their relationships and care delivery needs. This study found that although a variety of approaches were used, CFs needed more communication processes to actively support clinical teams of organisations to communicate about student progress and concerns.

The following recommendations are ways in which the clinical teams of HSPs and HEPs can manage risk more effectively:

- A website with a database such as 'Sonia' (Planet software, 2019) should be developed to improve communication between parties involved in RN training, to improve the learning needs of students and to foster more collaborative partnering between nurses and providers of student support. The website should provide an opportunity for students and supervisors to update feedback, identify students' learning objectives and provide resources related to the clinical area. Such a website would provide a platform and process for CFs to work across institutional boundaries; a mentoring structure; a repository of

resources for facilitation and supervision; and a platform for networking. This will require state, federal or private funding to foster collaborative partnering between nurses, providers and students.

- As students on a final placement require every opportunity to become independent in the provision of nursing care, HEPs and HSPs should place students on a final placement in clinical areas that are commensurate with their learning needs, such as high acuity areas. This practice period should allow students the time to settle, develop their skills and manage the load that a RN must manage.

8.2.2 Recommendation 2: For Health Service Providers

Health workplaces utilise approaches that best suit them in the delivery of patient nursing care. Therefore, ways that students can access opportunities to practice their skills must be considered. This study found that although the team approach was useful for best utilising the skill mix of available staff, it could give a false impression to students that they were completing the work of a RN. Students on their final placement in a team approach context were identified as undertaking less complex tasks and having less opportunity to make decisions about patient care. The differences in nursing practices among specialties was also a relevant factor in developing the necessary student competency.

This study found that HSPs should prepare CSs for the impending arrival of students. Although CFs are seen as the bridge or the connection between organisations, they do not always prepare CSs for the arrival of students. As the relationship between the CS and student is becoming increasingly transient in the current health setting, more information is warranted to capture evidence about students' progression.

Recommendations for HSPs hosting student final placements are:

- HSPs should formally prepare CSs for the impending arrival of students, including the expectations of those students and their CF. These expectations should also be transmitted to the HEP and through them to the final placement students and CFs.
- When a team nursing approach is utilised, students on a final placement should be given increasingly more control of the decision making and practice of

nursing care for the total care of patients' needs to a level at which a RN is expected to manage.

- The manager of the clinical area should ensure that students are placed with CSs who work the full period of the student's shift so that the student is given opportunities to undertake handovers, have their written notes checked and receive an analysis of their patient care and feedback on the attainment of their learning objectives. In cases where this is not possible, students should be notified prior to their shift about who is responsible for undertaking these tasks.
- Student nurses and CFs should be given access to specialty information that is specific to the clinical areas that outline the organisation's expectations for specific nursing skills or knowledge.
- Students in transition from the EN to the RN role on a final placement should ideally be assigned a RN to supervise their final practice.
- All students on a final placement should be offered the opportunity to attend clinical education sessions offered to members of the HSS during the duration of the placement.
- Students on a final placement must be made cognisant of the auditing processes utilised by nurses in clinical areas. Students should then be offered opportunities to contribute to the development of quality improvement.
- The student's orientation process to the health setting should be conducted by the HSP rather than the CF to ensure that the provider can be confident that the orientation process meets the occupational health and safety standards expected by the organisation.

8.2.3 Recommendation 3: For Higher Education Providers

CFs rely on a network of colleagues to debrief, gain support, exchange views and information, and discuss ways to deal with risk. To manage risk effectively and as gatekeepers of the nursing profession, CFs need to have their voices heard—not only by colleagues or through research studies but in the everyday work context.

CF participants know little about the process of remediation after struggling students have been removed from the health setting. CFs and CSs will benefit from understanding these processes and this knowledge will develop trust and create greater confidence in the HEP.

CF participants in this study raised issues about working alongside other providers such as CF colleagues who were struggling, were new to the role or were from another HEP who had a different ethos or education approach. They also saw other HEP's students in distress but did not feel empowered to intervene. The study highlighted the need for HEPs to collaboratively determine sustainable processes that enable the voices of those who supervise and facilitate students to be heard, both in the specific provider's context and across the range of providers.

CFs who identify new solutions to common problems should have their voices heard so that solutions can be reviewed and considered across a wider context. A collaborative process between providers and CFs could extend support to other HEPs' students or CFs. This relationship recognises the value of the CF's input.

Recommendations for HEPs are:

- Each HEP should provide information to CFs and other supervising staff about the process of remediation for struggling students removed from the health setting. Such processes should outline the re-testing of students and the justifications for re-placing students.
- As the partnering of training and service providers is vital for student nurse training and supervisory support, it is essential that a collaborative process is established to support new CFs, supervisors and students. These strategies should extend to introducing protocols or networking opportunities for CFs to extend their support to their peers and distressed students from other HEPs.
- HEPs should assist or guide CFs to develop the five core skills of understanding and working with research, ethical issues, management, leadership and advocacy. This training should extend to issues related to the CLE and personal development and could be given as learning packages, or as part of debriefing sessions.
- The providers of nursing education need to provide resources to CFs and to HSS so that they can more easily identify and assess how students comprehend the English language and communicate during their placements. The tool should be part of the assessment process that CFs and nursing supervisors can use to assess, identify and manage risk seen in student communication and comprehension.

8.2.4 Recommendation 4: For Clinical Facilitators

CF participants in this study expressed their desire to build trust with individuals involved in final student placements, particularly the students and HSS. CFs also identified their need for formal and informal debriefing and feedback processes, provided both by their peers and their employers. The study concluded that these processes would increase CF confidence and decrease workplace stress, especially when working in areas outside of their expertise.

Recommendations for BPCF are:

- CFs should ensure final-placement students are provided with the duty list of the RN for each specialty area. The duty list outlines to new employees the specific clinical and employee expectations for their role as the RN. This ensures they have an understanding of their role.
- As CFs require quality feedback from students and nurse supervisors, they should prepare questions for the students and HSS to obtain feedback about specific skills and approaches to nursing care. This will assist supervisors to monitor and determine student competency to be a RN.
- To improve their facilitation role, CFs should develop, implement and evaluate an approach to obtain anonymous feedback from students and HSS about the support they have provided. Facilitators should also continue to request feedback from their HEP about how they have met key performance indicators.
- CFs should initially meet with final-placement students, and in particular debrief them on the CFs expectations of the CFs role with HSS and students. Outlining these expectations will build on transparency about CFs' expectations and their use of the LDP.
- As building relationships is essential for a quality facilitation process, CFs should meet with selected HSS to identify processes that the HSS would prefer that CFs adopt and to discuss issues that they as CFs experience.
- CFs should request that their HEPs develop and provide processes or techniques to assist CFs to manage the support of students and other CFs, and to support other facilitators or other students who they notice are distressed in the health setting.

- As debriefing is likely to remove doubt about the way that CFs have managed risk, they should request regular meetings with their HEP faculty member for debriefing, to identify resource constraints and work through specific issues related to their facilitation role.
- As specialty areas have varying expectations for nursing practice, CFs should develop a guideline to focus on areas to assess students that are specific to the specialty area. These differences should consider variations used in recording in notes, assessments and acronyms specific to the setting, medications specific to specialty areas and differences in handover techniques and nursing care.

8.2.5 Recommendation 5: For Further Research

This study has addressed gaps in the literature about assessment processes, relationships with individuals, students and providers, the use of resources and their ability to manage in specialty settings outside their expertise. This study focussed on the lived experiences of CFs rather than the frequency or scale of risk, and identified areas that require further investigation.

Some CFs had expected students to attain the level of independent practice; however, contextual factors provided for students hindered their ability to practice independently on a final placement. On entering employment, new nurses must be able to manage a case load of patients. However, this seems difficult to achieve. CFs will benefit from having further clarification about the terms used to describe readiness for practice as the attainment of work readiness and competency.

Recommendations for further research:

- Clarify how specialty areas utilise or expand the student's scope of practice when on a final placement.
- Identify specific barriers related to how CFs I, A & M the various backgrounds of cultural practices in international RNs transitioning through educational pathways to the Australian health setting.
- Undertake a review of how CFs assess the delegation of care.
- Examine how to grade risk and the likelihood of risk, which will assist CFs I, A & M this risk. This grading of risk should be related to the work

environment, the CFs themselves, the students, CALD and the quality of supervision in the health setting.

- Examine how personality clashes arise in final placement as a result of the process used in facilitation and in the practices of nursing care. Such research will provide a clearer distinction between the roles of processes, attitudes, attributes and backgrounds in the clash.
- Examine how an EN transitions to the role of the RN and how they are hindered or supported on a final placement by the scope of practice, and being supervised by another EN or a new graduate.
- Examine how specialty areas utilise or expand the student's scope of practice when on a final placement to inform the CF, HEP and HSP of the different interpretations of the students' scope of practice.
- Examine how to quantify how CFs assess and determine readiness for practice as concepts of work readiness, independence, competency and safe provision of care. Such research will clarify the expectations for making decisions about student independence with a nurse's complete case load for nursing care, for only part of the case load, or as part of the team or task approach. It will also clarify how the terms used relate to the *Registered Nurse Standards for Practice* (2016) and the NCAS (Brown, 2016).

8.3 Conclusion

This interpretative study described how the readiness of students was influenced by external and internal barriers presented by organisational structures, workplace cultures and individual attributes through the lived experiences of CFs. These findings describe the dedication and complexity that participants had brought to the role of the Western Australian facilitator of a student on a final placement. The importance of these findings extends the need for formal and informal opportunities to debrief, network and mentor inexperienced CFs who take up the role of facilitation.

However, the role of clinical facilitation requires a collaborative and creative approach from the HEP and the HSP to put in place the necessary systems to manage issues and to assess risks. By integrating systems to manage the identification, assessment and management of risk, the tensions between the CF, student, and HSS will decrease and

allow more sustainable connections to be made between individuals and providers. Supportive structures and integrated systems to communicate about the identification, assessment and management of risk will guarantee that the relationships between individuals and providers will support quality in the processes used to I, A & M risk. These systems will sustain and develop the connections between supervisors and facilitators to support student readiness.

Epilogue

I commenced this study to understand how CFs had managed risk. The depth and breadth of participants' experiences provided me with greater insight into what dilemmas they had experienced. I felt privileged that they would share their stories with me. At times I was surprised by what they revealed. Although my participants had differing experiences, overall, my personal experiences were validated. My concerns about placement support were also validated by the recent literature.

I am thankful that Sherrill Conroy had published her use of the interpretative approach as it helped me to focus on my participants' stories. I wanted to provide evidence to demonstrate the use of this approach, as initially I had struggled to understand how this was to be used. The result was that the linking of principles, commentaries and authentic behaviour in many places has made the methodology, findings and other chapters larger than expected. I hope that this approach is useful for other researchers.

Since undertaking this analysis, I have reconsidered how I may turn towards or away from authentic behaviour. I understand how difficult it can be to 'swim against the current' and how easy it can be 'to go with the flow', particularly when you do not have adequate support. However, we all have competing values and these values will change according to the emerging needs of individuals and organisations. To this end, I have gained further understanding that evaluating not just my own view, but all views is important to understand how best to support facilitators.

As a facilitator, I have a clearer understanding of the dimensions and modes of facilitation and why we as CFs may turn towards or away from relying on others or on ourselves. As an educator, it has become clearer to me that student competency does not necessarily equate to independent practice of a full case load of patients. The organisational contexts of placements, resources and relationships may prevent this from occurring. To this end, my expectations about students achieving independent practice have altered. In this current context of placement opportunities for practice and support, students can attain and provide a safe level of nursing care needs with a partial case load of patients. However, once registered, they will not be able to manage the full workload of the RN without workplace support.

In looking back over the volume of study I have undertaken since 2008, I realise how much it has shaped who I am today. I encourage nurses to continue formal education as it changes how you think and how you act. In closing, I hope these findings will be taken up by organisational providers and facilitators to improve how support is provided to students. For new CFs, I hope that these findings will assist you to better manage the obstacles you encounter, to reduce your anxiety, encourage you to promote authentic behaviour and help you to understand the contexts and factors that may hamper your ability to facilitate effectively.

References

- Ajjawi, R., & Higgs, J. (2007). Using hermeneutic phenomenology to investigate how experienced practitioners learn to communicate clinical reasoning, *12*(4), 612–638. Retrieved from <http://www.nova.edu/ssss/OR/QR12-4/ajjawi.pdf>
- Alderman, J. (2017). *What is the influence of clinical experience on the nursing student's understanding of patient centered care?* (Master's thesis, University of Adelaide, SA). Retrieved from <https://digital.library.adelaide.edu.au/dspace/bitstream/2440/106419/2/02who-le.pdf>
- Amicucci, B. (2011). Clinical nurse faculty and the lived experience of clinical grading (Doctoral dissertation, The City University of New York, NY). Retrieved from Proquest Dissertations and Theses database. (UMI No. 3443927)
- Amicucci, B. (2012). What nurse faculty have to say about clinical grading. *Teaching & Learning in Nursing*, *7*(2), 51–55. <https://doi.org/10.1016/j.teln.2011.09.002>
- Australian Commission on Safety and Quality in Healthcare. (2010). *The OSSIE guide to clinical handover improvement*. Sydney, ACSQHC. Retrieved from <https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/ossie.pdf>
- Australian Commission on Safety and Quality in Healthcare. (2011). *National consensus statement: Essential elements for recognising & responding to clinical deterioration*. Sydney, NSW: Author. Retrieved from https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/national_consensus_statement.pdf

- Australian Government National Health and Medical Research Council. (2007). *National Statement on Ethical Conduct in Human Research (2007) (National Statement)*. Retrieved from <https://www.nhmrc.gov.au/sites/default/files/documents/attachments/National%20Statement/e72.pdf>
- Australian Learning and Teaching Council & Healthworkforce Australia. (2016). *Guidance package—Nursing competency assessment schedule (NCAS)*. Retrieved from http://www.cdnm.edu.au/assets/ncas_rn-standards_v6.2_25-09-2016.pdf
- Australian Learning and Teaching Council. (2014). *Australian Nursing Standards Assessment Tool: ANSAT resource manual*. Canberra, ACT: Office for Learning and Teaching, Department of Education & Training. Retrieved from www.ansat.com.au
- Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog. *British Medical Journal*, 5(322), 1115–1117. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1120242/?tool=pmcentrez&rendertype=abstract>
- Benner, P. (1994). *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness*. Thousand Oaks, CA: Sage. Retrieved from <https://www.amazon.com/Interpretive-Phenomenology-Embodiment-Artificial-Intelligence/dp/0803957238>
- Berry, R. S. Y. (1999, September). *Collecting data by in-depth interviewing*. Paper presented at the British Educational Research Association Annual Conference,

- University of Sussex at Brighton, UK. Retrieved from <http://www.leeds.ac.uk/educol/documents/000001172.htm>
- Bessant, B. (1999). Milestones in Australian nursing. *Collegian*, 6(4), 1–3. [https://doi.org/doi:10.1016/S1322-7696\(08\)60610-1](https://doi.org/doi:10.1016/S1322-7696(08)60610-1)
- Billups, F. (2014). The quest for rigor in qualitative studies: Strategies for institutional researchers. *The NERA Researcher*, 52(1), 10–15. Retrieved from http://www.nera-education.org/docs/TNR_Fall_2014_Color_Final.pdf
- Birks, M., Bagley, T., Park, T., Burkot, C., & Mills, J. (2017). The impact of clinical placement model on learning in nursing: A descriptive exploratory study. *Australian Journal of Advanced Nursing*, 34(3), 16–24.
- Birks, M., Budden, L., Biedermann, P., Park, T., & Chapman, Y. (2018). A ‘rite of passage?’: Bullying experiences of nursing students in Australia. *Collegian*, 25(1), 45–50. <https://doi.org/10.1016/j.colegn.2017.03.005>
- Birks, M., Cant, R. P., Budden, L. M., Russell-Westhead, M., Sinem Üzar Özçetin, Y., & Tee, S. (2017). Uncovering degrees of workplace bullying: A comparison of baccalaureate nursing students’ experiences during clinical placement in Australia and the UK. *Nurse Education in Practice*, 25(Supplement C), 14–21. <https://doi.org/10.1016/j.nepr.2017.04.011>
- Black, S. (2011). *Being a mentor who fails a pre-registration nursing student in their final placement: Understanding failure* (Doctoral dissertation, London South Bank University, UK). Retrieved from <http://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.570876>
- Blattner, W. (1979). *Temporality Why being*. Retrieved from <http://faculty.georgetown.edu/blattnew/topics/docs/temporality.pdf>

- Bloom, B., Engelhart, D., Furst, E., Hill, W., & Krathwohl, D. (1956). *Taxonomy of educational goals: The classification of educational goals. Handbook 1 Cognitive domain*. London: Longmans, Green and Co. Retrieved from <https://www.uky.edu/~rsand1/china2018/texts/Bloom%20et%20al%20-Taxonomy%20of%20Educational%20Objectives.pdf>
- Bloomberg, L., & Volpe, M. (2012). *Completing your qualitative dissertation: A road map from beginning to end* (2nd ed.). Thousand Oaks, CA: Sage.
- Bondy, K. (1983). Criterion-referenced definitions for rating scales in clinical evaluation. *Journal of Nursing Education*, 22(9), 376–382.
- Borrott, N., Day, G. E., Sedgwick, M., & Levett-Jones, T. (2016). Nursing students' belongingness and workplace satisfaction: Qualitative findings of a mixed methods study. *Nurse Education Today*, 45, 29–34. <https://doi.org/10.1016/j.nedt.2016.06.005>
- Brammer, J. (2008). RN as gatekeeper: Gatekeeping as monitoring and supervision. *Journal of Clinical Nursing*, 17(14), 1868–1876. <https://doi.org/10.1111/j.1365-2702.2008.02376.x>
- Brink, P., & Wood, M. (1988). *Basic steps in planning nursing research: From question to proposal* (3rd ed.). Boston, MA: Jones and Bartlett Publishers.
- Broadbent, M., Moxham, L., Sander, T., Walker, S., & Dwyer, T. (2014). Supporting Bachelor of Nursing students within the clinical environment: Perspectives of preceptors. *Nurse Education in Practice*, 14, 403–409. <https://doi.org/10.1016/j.nepr.2013.12.003>
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health*, 21(1), 87–108. <https://doi.org/10.1080/14768320500230185>

- Brown, R. (2016). *The development of a pre-registration nursing competency assessment schedule (NCAS) for use in Australian universities* (PhD thesis, University of Wollongong, NSW). Retrieved from <http://ro.uow.edu.au/theses/4930>
- Brown, R. A., & Crookes, P. A. (2016a). What are the 'necessary' skills for a newly graduating RN? Results of an Australian survey. *BMC Nursing*, *15*(45), 1–8. <https://doi.org/10.1186/s12912-016-0144-8>
- Brown, R. A., & Crookes, P. A. (2016b). What level of competency do experienced nurses expect from a newly graduated registered nurse? Results of an Australian modified Delphi study. *BMC Nursing*, *15*(1), 45. <https://doi.org/10.1186/s12912-016-0166-2>
- Brown, R. A., & Crookes, P. A. (2017). How do expert clinicians assess student nurses competency during workplace experience? A modified nominal group approach to devising a guidance package. *Collegian*, *24*(3), 219–225. <https://doi.org/10.1016/j.colegn.2016.01.004>
- Brown, R. A., Crookes, P. A., & Iverson, D. (2015). An audit of skills taught in registered nursing preparation programmes in Australia. *BMC Nursing*, *14*(68), 1–8. <https://doi.org/10.1186/s12912-015-0113-7>
- Browning, M., & Pront, L. (2015). Supporting nursing student supervision: An assessment of an innovative approach to supervisor support. *Nurse Education Today*, *35*(6), 740–745. <https://doi.org/10.1016/j.nedt.2015.02.003>
- Budden, L. M., Birks, M., Cant, R., Bagley, T., & Park, T. (2015). Australian nursing students' experience of bullying and/or harassment during clinical placement. *Collegian*, *24*, 125–133. <https://doi.org/10.1016/j.colegn.2015.11.004>

- Burke, W. W., & Litwin, G. H. (1992). A causal model of organizational performance and change. *Journal of Management*, 18(3), 523–545. <https://doi.org/10.1177/014920639201800306>
- Burns, H. K., Brand, S., & Millard, L. (2010). Leveraging differences for collaborative advantage: Enhancing student learning through an international educational collaboration. *International Journal of Nursing Scholarship*, 7(1), Article 45. <https://doi.org/10.2202/1548-923X.1944>
- Burns, N., & Grove, S. (1993). *The practice of nursing research: Conduct, critique & utilization* (2nd ed.). Philadelphia, PA: W.B. Saunders Company.
- Calleja, P., Harvey, T., Fox, A., & Carmichael, M. (2016). Feedback and clinical practice improvement: A tool to assist workplace supervisors and students. *Nurse Education in Practice*, 17, 167–173. <https://doi.org/10.1016/j.nepr.2015.11.009>
- Cashin, A., Heartfield, M., Bryce, J., Devey, L., Buckley, T., Cox, D., ... Fisher, M. (2017). Standards for practice for registered nurses in Australia. *Collegian*, 24(2017). <https://doi.org/10.1016/j.colegn.2016.03.002>
- Cassidy, S., Coffey, M., & Murphy, F. (2017). ‘Seeking authorization’: A grounded theory exploration of mentors’ experiences of assessing nursing students on the borderline of achievement of competence in clinical practice. *Journal of Advanced Nursing*, 73(9), 2167–2178. <https://doi.org/10.1111/jan.13292>
- Chan, Z. C. Y., Fung, Y., & Chien, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process? *Qualitative Report*, 18(59), 1–9. <https://doi.org/doi:10.1016/j.compedu.2014.11.001>
- Christensen, M., Aubeeluck, A., Fergusson, D., Craft, J., Knight, J., Wirihana, L., & Stuppel, E. (2016). Do student nurses experience imposter phenomenon? An

international comparison of final year undergraduate nursing students readiness for registration. *Journal of Advanced Nursing*, 72(11), 2784–2793.

<https://doi.org/10.1111/jan.13034>

Cienfuegos, I. (2013). Risk management theory: The integrated perspective and its application in the public sector. *Estado, Gobierno, Gestión Pública*, 21, 89–126. <https://doi.org/10.5354/0717-6759.2013.29402>

Cohen, M., Kahn, D., & Steeves, R. (2000). *Hermeneutic phenomenological research: A practical guide for nurse researchers*. Thousand Oaks, CA: Sage.

Conroy, S. A. (2001). *Moral inclinations of medical, nursing, and physiotherapy students*. Unpublished doctoral dissertation, University of Oxford, Oxford).

Conroy, S. A. (2003). A pathway for interpretive phenomenology. *International Journal of Qualitative Methods*, 2(3), 36–62. <https://doi.org/10.1177/160940690300200304>

Coyne, E., & Needham, J. (2012). Undergraduate nursing students' placement in speciality clinical areas: Understanding the concerns of the student and registered nurse. *Contemporary Nurse*, 42(1), 97–104. <https://doi.org/10.5172/conu.2012.42.1.97>

Craven, M. (2015). *Processes used by nursing faculty when working with underperforming students in the clinical area: A theoretical model derived from grounded theory* (Doctoral dissertation, Indiana University, PA).

Retrieved from

https://scholarworks.iupui.edu/bitstream/handle/1805/7345/Craven_iupui_0104D_10005.pdf;sequence=1

Deasy, C., Doody, O., & Tuohy, D. (2011). An exploratory study of role transition from student to registered nurse (general, mental health and intellectual

disability) in Ireland. *Nurse Education in Practice*, 11(21), 109–113.

<https://doi.org.10.1016/j.nepr.2010.11.006>

Deegan, J., Burton, T., & Rebeiro, G. (2007). Clinical assessment and the benefit of the doubt: What is the doubt? *Australian Journal of Advanced Nursing*, 30(4), 42–48. Retrieved from <http://www.ajan.com.au/Vol30/Issue1/Deegan.pdf>

Deegan, J., & Simkin, K. (2010). Expert to novice: Experiences of professional adaptation reported by non-English speaking nurses in Australia. *Australian Journal of Advanced Nursing*, 27(3), 31–37.

Denzin, N. K., & Lincoln, Y. S. (2018). *The SAGE handbook of qualitative reasearch* (5th ed.). [Kindle Version]. Thousand Oaks, CA: Sage.

Denzin, N., & Lincoln, Y. (Eds.) (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Department of Health. (2013). *Appendix iv: History of commonwealth involvement in the nursing and midwifery workforce*. Retrieved from <http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~appendices~appendix-iv-history-commonwealth-involvement-nursing-midwifery-workforce>

Department of Health & Human Services. (2005). *Prepare nurses for the future: Report—Phase 1*. Melbourne, VIC: Nurse Policy Branch. Retrieved from http://www.health.vic.gov.au/_data/assets/pdf_file/0003/17652/preparenurses_phase1.pdf

Department of Health & Human Services. (2009). *Best practice clinical learning environments within health services for undergraduate and early-graduate*

learners: Final report. Melbourne, VIC: Darcey Associates. Retrieved from <https://tlap.ksu.edu.sa/sites/tlap.ksu.edu.sa/files/attach/ref20.pdf>

Department of Health & Human Services. (2016a). *The Best Practice Clinical Learning Environment Framework: Delivering quality clinical education for learners*. Melbourne, VIC: Author. Retrieved from https://bpacletool.net.au/media/medialibrary/2016/09/BPCLE_Framework_Aug_2016.pdf

Department of Health and Human Services. (2016b). *Best Practice Clinical Learning Environment Performance Monitoring Framework: Data collection and reporting guidelines 2nd Edition*. Retrieved from https://bpacletool.net.au/media/medialibrary/2016/09/BPCLE_PMF_Aug_2016.pdf

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, 40(4), 314–321. <https://doi.org/10.1111/j.1365-2929.2006.02418.x>

Donnelly, F. (2012). *The influence of clinical placement and experiential learning on student nurse development: An exploratory case study* (PhD thesis, University of Adelaide, SA). Retrieved from <https://digital.library.adelaide.edu.au/dspace/bitstream/2440/91213/4/01front.pdf>

Doyle, K., Sainsbury, K., Cleary, S., Parkinson, L., Vindigni, D., McGrath, I., & Cruickshank, M. (2017). Happy to help/happy to be here: Identifying components of successful clinical placements for undergraduate nursing students. *Nurse Education Today*, 49, 27–32. <https://doi.org/https://doi.org/10.1016/j.nedt.2016.11.001>

- Dreyfus, H. L. (1991). *Being-in-the-world: A commentary on Heidegger's being and time*, division 1. Cambridge, MA: MIT Press
- Duffield, C., Roche, M., Diers, D., Christine, C.-P., & Blay, N. (2010). Staffing, skill mix and the model of care. *Journal of Clinical Nursing*, *19*(16–16), 2242–2251. <https://doi.org/https://doi.org/10.1111/j.1365-2702.2010.03225.x>
- Duffy, K. (2003). *Failing students: A qualitative study of factors that influence the decisions regarding assessment of students' competence in practice*. Glasgow, Scotland: Caledonian Nursing and Midwifery Research Centre.
- Duffy, K. (2013). Deciding to fail: Nurse mentor's experiences of managing a failed practice assessment. *Journal of Practice Teaching & Learning*, *11*(May), 36–58. <https://doi.org/10.1921/2102110304>.
- Edgecombe, K., Jennings, M., & Bowden, M. (2013). International nursing students and what impacts their clinical learning: Literature review. *Nurse Education Today*, *33*(2), 138–142. <https://doi.org/10.1016/j.nedt.2012.07.015>
- Elliott, D., McKinley, S., Perry, L., Duffield, C., Iedema, R., Gallagher, R., ... Allen, E. (2014). Clinical utility of an observation and response chart with human factors design characteristics and a track and trigger system: Study protocol for a two-phase multisite multiple-methods design. *Journal of Medical Internet Research*, *16*(8), e40. <https://doi.org/10.2196/resprot.3300>
- Etikan, I., & Bala, K. (2017). Sampling and sampling methods. *Biometrics & Biostatistics International Journal*, *5*(6), 5–7. <https://doi.org/10.15406/bbij.2017.05.00149>
- Evernote Corporation. (2015). *Evernote*. Retrieved from <https://evernote.com>
- Fawcett, J. (2005). *Contemporary nursing knowledge: Analysis and evaluation of nursing models and theories* (2nd ed.). Philadelphia, PA: F.A. Davis Company.

- Ferguson, L., & Cioffi, J. (2011). Team nursing: Experiences of nurse managers in acute care settings. *Australian Journal of Advanced Nursing*, 28(4), 5–11. Retrieved from <https://www.google.com.au>
- Forrester, M. A. (Ed.) (2010). *Doing qualitative research in psychology: A practical guide*. London, UK: Sage.
- Gadamer, H. G. (1989). *Truth and method* (2nd ed., J. Weinshaner & D. G. Marshall, Trans.). London, UK: Sheed & Ward.
- Gentles, C.J., Charles, C., Phloeg., J. & McGibbon, K.A. (2015). Sampling in qualitative research: Insights from an overview of the methods literature. *The Qualitative Report*, 20(11), 1772-1789. Retrieved from <http://nsuworks.nova.edu/tqr/vol20/iss11/5>
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *Qualitative Report*, 8(4), 597–606. Retrieved from <http://nsuworks.nova.edu/cgi/viewcontent.cgi?article=1870&context=tqr>
- Grant, M., Leigh, J., Murray, C., & Howarth, M. (2007). *The role of the academic in clinical practice: A systematic review*. Retrieved from http://usir.salford.ac.uk/18144/1/AiP_Report.pdf
- Grbich, C. (1999). *Qualitative research in health: An introduction*. London, UK: Sage.
- Gregory, D., Guse, L., Dick, D., Davis, P., & Russell, C. (2008). *The question of safety: An exploration of errors among undergraduate nursing students placed on clinical learning contracts*. A Research Report Submitted to the Manitoba Institute for Patient Safety (MIPS). Retrieved from <https://hdl.handle.net/10133/692>
- Griffith University. (2014). *Australian Nursing Standards Assessment Tool: ANSAT resource manual*. Retrieved from www.ansat.com.au

- Grove, N., Burns, N., & Gray, J. (2012). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (7th ed.). St Louis, MO: Elsevier Health Sciences. Retrieved from <https://www.elsevier.com/books/the-practice-of-nursing-research/grove/978-1-4557-0736-2>
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Thousand Oaks, CA: Sage. http://ls-tlss.ucl.ac.uk/course-materials/PRIMG024_74408.pdf
- Haddad, M. E. (2016). *Grounded theory examination of the perspective of practice and education sectors regarding graduate registered nurse practice readiness in the Australian context* (PhD thesis, University of Wollongong, NSW). Retrieved from <https://trove.nla.gov.au/work/215177049>
- Hagens, V., Dobrow, M. J., & Chafe, R. (2009). Interviewee transcript review: Assessing the impact on qualitative research. *BMC Medical Research Methodology*, 9(1), 47. <https://doi.org/10.1186/1471-2288-9-47>
- Hall, H. (1993). Intentionality and world: Division one of being and time. In C. Guignon (ed.), *The Cambridge companion to Heidegger* (pp. 122–140). Cambridge, UK: Cambridge University Press.
- Hanson, J., & McAllister, M. (2017). Preparation for workplace adversity: Student narratives as a stimulus for learning. *Nurse Education in Practice*, 25, 89–95. <https://doi.org/10.1016/j.nepr.2017.05.008>
- Harcourt, L. P., & Cornell, C. (2015). The systems theory of management in modern day organizations—a study of Aldgate Congress Resort. *International Journal of Scientific & Research Publications*, 5(9), 1–7. Retrieved from

<https://pdfs.semanticscholar.org/d1e4/03a4a017d00b081122c2a0abd1d7317f14fe.pdf>

Haywood, S. (2009). *Evaluation of a change programme: Model of nursing care delivery*. (Masters dissertation) Retrieved from https://www.nzno.org.nz/Portals/0/Docs/Services/Library/2009%20HAYWARD_S%20-%20Evaluation%20of%20a%20change%20programme%20model%20of%20nursing%20care%20delivery.pdf?ver=2010-02-04-144433-347

Hathorn, D. C. (2006). *The lived experience of nurses working with student nurses in the acute care clinical environment* (Doctoral dissertation, Phd thesis) Retrieved from Proquest Dissertations and Theses database. (UMI No. 3244962)

Health Workforce Australia. (2010). *Clinical Supervisor Support Program—discussion paper*. Adelaide, SA: Author. Retrieved from <http://www.hwa.gov.au/sites/default/files/clinical-supervision-support-program-discussion-paper-26-07-2010.pdf>

Health Workforce Australia. (2011). *Clinical supervision support program directions paper*. Adelaide, SA: Author. Retrieved from <http://www.hwa.gov.au/sites/uploads/clinical-supervision-support-program-directions-paper-april-2011.pdf>

Health Workforce Australia. (2012). *Promoting quality in clinical placements: Literature review and national stakeholder consultation. Final report*. Adelaide, SA: Siggins Miller. Retrieved from <https://docplayer.net/10887025-Promoting-quality-in-clinical-placements-literature-review-and-national-stakeholder-consultation-final-report.html>

- Health Workforce Australia. (2013). *National guidelines for clinical placement agreements*. Adelaide, SA: Author. Retrieved from http://www.hwa.gov.au/sites/default/files/HWA_National-guidelines-for-clinical-placement-agreements.pdf
- Health Workforce Australia. (2014a). *Australia's future health workforce—nurses overview report*. Canberra, ACT: DOH. Retrieved from [https://www.health.gov.au/internet/main/publishing.nsf/Content/34AA7E6FDB8C16AACA257D9500112F25/\\$File/AFHW - Nurses overview report.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/34AA7E6FDB8C16AACA257D9500112F25/$File/AFHW_-_Nurses_overview_report.pdf)
- Health Workforce Australia. (2014b). *Clinical training profile: Nursing*. Adelaide, SA: Author. Retrieved from http://pandora.nla.gov.au/pan/133228/20150419-0017/www.hwa.gov.au/sites/default/files/HWA_Clinical_Training_Profile_Nursing_LR.pdf
- Heidegger, M. (1926). *Being and time* (7th ed.; J. Macquarrie & E. Robinson, Trans.). Oxford, UK: Blackwell. Retrieved from <http://pdf-objects.com/files/Heidegger-Martin-Being-and-Time-trans.-Macquarrie-Robinson-Blackwell-1962.pdf>
- Helminen, K. (2017). *Nursing students final assessment in clinical practice: Perceptions of teachers, students and mentors* (Dissertation, University of Eastern Finland, Kuopio). Retrieved from http://epublications.uef.fi/pub/urn_isbn_978-952-61-2420-9/urn_isbn_978-952-61-2420-9.pdf
- Henderson, A., Twentyman, M., Heel, A., & Lloyd, B. (2006). Students' perception of the psycho-social clinical learning environment: An evaluation of placement models. *Nurse Education Today*, 26(7), 564–571. <https://doi.org/10.1016/j.nedt.2006.01.012>

- Henry, T., & Murry, J. (2018). How does it feel? The affective domain and undergraduate student perceptions of fieldwork set in a broad perspective. *Tuning Journal for Higher Education*, 5(2), 45–74. [https://doi.org/10.18543/tjhe-5\(2\)-2018](https://doi.org/10.18543/tjhe-5(2)-2018)
- Heron, J. (1999). *The complete facilitator's handbook*. Retrieved from <http://www.human-inquiry.com/cfh.pdf>
- Hopkins, M., Featherstone, C. M., & Morrison, P. (2014). Prevalence and characteristics of aggression and violence experienced by Western Australian nursing students during clinical practice. *Contemporary Nurse* (2014), 49(December), 113–121. <https://doi.org/10.1080/10376178.2014.11081961>
- Hornsby, R. (1991). *What Heidegger means by being-in-the-world*. Retrieved from <http://www.royby.com/philosophy/pages/dasein.html>
- Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the key tenets of Heidegger's philosophy for interpretive phenomenological research. *International Journal of Qualitative Methods*, 15(1), 1–8. <https://doi.org/10.1177/1609406916680634>
- Hoy, D. C. (1993). Heidegger and the hermeneutic turn. In C. Guignon (Ed.), *The Cambridge companion to Heidegger* (pp. 170–193). Cambridge, UK: Cambridge University Press.
- Hunt, L. A., McGee, P., Gutteridge, R., & Hughes, M. (2016a). Manipulating mentors' assessment decisions: Do underperforming student nurses use coercive strategies to influence mentors' practical assessment decisions? *Nurse Education in Practice*, 20, 154–162. <https://doi.org/10.1016/j.nepr.2016.08.007>

- Hunt, L. A., McGee, P., Gutteridge, R., & Hughes, M. (2016b). Failing securely: The processes and support which underpin English nurse mentors' assessment decisions regarding under-performing students. *Nurse Education Today*, 39, 79–86. <https://doi.org/10.1016/j.nedt.2016.01.011>
- Jacob, E., McKenna, L., & D'Amore, A. (2017). Role expectations of different levels of nurse on graduation: A mixed methods approach. *Collegian*, 24, 135–145.
- Jacob, E., Sellick, K., & McKenna, L. (2012). Australian registered and enrolled nurses: Is there a difference? *International Journal of Nursing Practice*, 18(3), 303–307. <https://doi.org/10.1111/j.1440-172X.2012.02037.x>
- Jeong, S. Y. S., Hickey, N., Levett-Jones, T., Pitt, V., Hoffman, K., Norton, C. A., & Ohr, S. O. (2011). Understanding and enhancing the learning experiences of culturally and linguistically diverse nursing students in an Australian Bachelor of Nursing program. *Nurse Education Today*, 31(3), 238–244. <https://doi.org/10.1016/j.nedt.2010.10.016>
- Karlstrom, M. (2018). *Unsafe student nurse behaviours: The perspectives of expert clinical nurse educators* (Master's thesis, University of British Columbia, Okanagan, Canada). Retrieved from https://macsphere.mcmaster.ca/retrieve/24230/Pratt_Maria_G_201608_Ph.d.pdf
- Kast, E., & Rosenzweig, J. (1972). General Systems Theory: Applications for organization and management. *Academy of Management Journal*, 15(4), 447–465. Retrieved from http://www.communicationcache.com/uploads/1/0/8/8/10887248/general_system_theory- applications_for_organization_and_management.pdf

- Katz, D., & Kahn, R.. (1978). *The socialisation psychology of organisations*. New York, NY: Wiley.
- Kealley, C. C. (2012). *Graduate nurse transition programs in Western Australia: A comparative study of their perceived efficacy* (ND thesis, University of Notre Dame, Fremantle, Australia). Retrieved from <https://researchonline.nd.edu.au/theses/75>
- Killam, L. A., Montgomery, P., Luhanga, F. L., Adamic, P., & Carter, L. M. (2010). Views on unsafe nursing students in clinical learning. *International Journal of Nursing Education Scholarship*, 7(1), Article 36. <https://doi.org/10.2202/1548-923X.2026>
- Killam, L., Montgomery, P., Raymond, J., Mossey, S., Timmermans, K., & Binette, J. (2012). Unsafe clinical practices as perceived by final year baccalaureate nursing students: Q methodology. *BMC Nursing*, 11(1), 26. <https://doi.org/10.1186/1472-6955-11-26>
- Killam, L., Mossey, S., Montgomery, P., & Timmermans, K. E. (2013). First year nursing students' viewpoints about compromised clinical safety. *Nurse Education Today*, 33(5), 475–480. <https://doi.org/10.1016/j.nedt.2012.05.010>
- Knowles, M. (1978). *The adult learner: A neglected species* (2nd ed.). Houston, TX: Gulf.
- Kuhn, T. S. (1970). *The structure of scientific revolutions. Philosophical review* (2nd ed., Vol. II). Chicago, IL: International Encyclopedia of Unified Science. Retrieved from <https://doi.org/10.1119/1.1969660>
- Kube, M. L. (2010). The relationship of nursing faculty clinical teaching behaviors to student learning. (Doctoral thesis, College of Saint Mary, Omaha, NE). Retrieved from <https://eric.ed.gov/?id=ED515024>

- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102–120. <https://doi.org/10.1191/1478088706qp062oa>
- Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3), 1–29. <https://doi.org/10.1177/160940690300200303>
- Lawrence, K. (2014). Innovation in clinical practice: Providing undergraduate nursing students with a best practice clinical learning environment. *Journal of Teaching & Education*, 3(1), 265–274. Retrieved from <http://universitypublications.net/jte/0301/pdf/R3ME85.pdf>
- Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Research & Audit*, 4(3), 2015–2018. <https://doi.org/10.4103/2249-4863.161306>
- Levett-Jones, T. (2007). *Belongingness: A pivotal precursor to optimising the learning of nursing students in the clinical environment*. University of Newcastle, NSW. Retrieved from <https://trove.nla.gov.au/work/35185242>
- Levett-Jones, T., Dwyer, T., Reid-Searl, K., Heaton, L., Flenady, T., Applegarth, J., ... Andersen, P. (2017). *The Patient Safety Competency Framework (PSCF) for nursing students*. Retrieved from http://www.proftlj.com/wp-content/uploads/2017/07/UTS_PSCF_Brochure_2.pdf
- Levett-Jones, T., & Lathlean, J. (2008). Belongingness: A prerequisite for nursing students' clinical learning. *Nurse Education in Practice*, 8(2), 103–111. <https://doi.org/10.1016/j.nepr.2007.04.003>

- Levett-Jones, T., & Lathlean, J. (2009). The Ascent to Competence conceptual framework: An outcome of a study of belongingness. *Journal of Clinical Nursing*, 18(20), 2870–2879. <https://doi.org/10.1111/j.1365-2702.2008.02593.x>
- Levett-Jones, T., Lathlean, J., Higgins, I., & McMillan, M. (2008). The duration of clinical placements: A key influence on nursing students' experience of belongingness. *Australian Journal of Advanced Nursing*, 26(2), 8–16.
- Levett-Jones, T., Lathlean, J., Higgins, I., & McMillan, M. (2009). Staff–student relationships and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing*, 65(2), 316–324. <https://doi.org/10.1111/j.1365-2648.2008.04865.x>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Lockwood, B. J. (2009). *Workplace culture and critical thinking*. (PhD thesis, University of Illinois, Chicago, IL). Retrieved from Proquest Dissertations and Theses database. (UMI No. 3381327)
- Luhanga, F., Myrick, F., & Yonge, O. (2010). The preceptorship experiences: An examination of ethical and accountability issues. *Journal for Nurses in Staff Development*, 24(5), 214–219. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/20869025>
- Luhanga, F., Yonge, O., & Myrick, F. (2008). Strategies for precepting the unsafe student. *Journal for Nurses in Staff Development*, 24(5), 214–219. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/18838899>
- Mabuza, H., Govender, I., Ogunbanjo, G., & Mash, B. (2014). African primary care research: Qualitative data analysis and writing results. *African Journal of*

Primary Health Care & Family Medicine, 6(1), 1–5.

<https://doi.org/10.4102/phcfm.v6i1.640>

Mackay, M. T., Brown, R. A., Joyce-McCoach, J. T., & Smith, K. M. (2014). The development of a model of education for casual academic staff who support nursing students in practice. *Nurse Education in Practice*, 14(3), 281–285.

<https://doi.org/10.1016/j.nepr.2013.08.005>

Mantzoukas, S. (2005). The inclusion of bias in reflective and reflexive research: A necessary prerequisite for securing validity. *Journal of Research in Nursing*, 10(3), 279–295. Retrieved from

[http://cris.teiep.gr/jspui/bitstream/123456789/1371/1/The inclusion of bias in reflective and reflexive research_A necassary prerequisite for securing validity.pdf](http://cris.teiep.gr/jspui/bitstream/123456789/1371/1/The%20inclusion%20of%20bias%20in%20reflective%20and%20reflexive%20research_A%20necassary%20prerequisite%20for%20securing%20validity.pdf)

Maslow, A. (1943). A theory of human motivation. *Psychology Review*, 50(4), 370–396. <http://dx.doi.org/10.1037/h0054346>

May, F., & Black, F. (2011). Formulating the evidence based practice question: A review of the frameworks. *Evidence-based Library & Information Practice*, (2006), 5–34. Retrieved from

<https://www.ncbi.nlm.nih.gov/pubmed/17706327>

McAllister, L., Nagarajan, S., Scott, L., Smith, L. & Thomson, K. (2018). Developing measures of clinical placement quality in allied health, dentistry, medicine, and pharmacy. *International Journal of Practice-based Learning in Health and Social Care*, 6(2), 31-47. <https://doi.org/10.18552/ijpblhsc.v6i2.493>

McCarthy, B., & Murphy, S. (2008). Assessing undergraduate nursing students in clinical practice: Do preceptors use assessment strategies? *Nurse Education*

- Today, 28(3), 301–313. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/17706327>
- McGregor, A. (2007). Struggling practices of a failing student. *Journal of Nursing Education, 46*(11), 504–511. Retrieved from CINAHL
- McInnes, S., Peters, K., Hardy, J., & Halcomb, E. (2015). Primary care clinical placements: The views of Australian registered nurse mentors and pre-registration nursing students (part 2). *Nurse Education in Practice, 15*(6), 443–449. <https://doi.org/10.1016/j.nepr.2015.04.004>
- Mero-Jaffe, I. (2011). ‘Is that what I said?’ Interview transcript approval by participants: An aspect of ethics in qualitative research. *International Journal of Qualitative Methods, 10*(3), 231–247. <https://doi.org/10.1177/160940691101000304>
- Michie, S., & Gooty, J. (2005). Values, emotions, and authenticity: Will the real leader please stand up? *Leadership Quarterly, 16*(3), 441–457. <https://doi.org/10.1016/j.leaqua.2005.03.006>
- Missen, K., McKenna, L., & Beauchamp, A. (2015). Work readiness of nursing graduates: Current perspectives of graduate nurse program coordinators. *Contemporary Nurse, 51*(1), 27–38. <https://doi.org/10.1080/10376178.2015.1095054>
- Missen, K., McKenna, L., Beauchamp, A., & Larkins, J. A. (2016). Qualified nurses’ rate new nursing graduates as lacking skills in key clinical areas. *Journal of Clinical Nursing, 25*(15–16), 2134–2143. <https://doi.org/10.1111/jocn.13316>
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred reporting item for systematic reviews and meta analysis. The

- PRISMA Statement. *PLoS Medicine*, 6(7): e1000097, 1-6. Retrieved from <https://doi.org/10.1371/journal.pmed.1000097>
- Murphy, F., & Yelder, J. (2010). Establishing rigour in qualitative radiography. *Radiography*, 16(1), 62–67. Retrieved from <https://doi.org/10.1016/j.radi.2009.07.003>
- Nash, R. (2007). *Collaboration in clinical education: Development, implementation and evaluation of an innovative model of clinical education for undergraduate nursing students* (PhD thesis, Queensland University of Technology, Brisbane, QLD). Retrieved from <https://trove.nla.gov.au/general/theses>
- Nash, R., Lemcke, P., & Sacre, S. (2009). Enhancing transition: An enhanced model of clinical placement for final year nursing students. *Nurse Education Today*, 29(1), 48–56. <https://doi.org/10.1016/j.nedt.2008.06.004>
- National Health Workforce Taskforce. (2009). *Health workforce in Australia and factors for current shortages*. Canberra, ACT. In consultation with KPMG Consulting. Canberra, ACT: Author. Retrieved from <https://www.voced.edu.au/content/ngv%3A53787>
- Needham, J. (2014). *Best practice in clinical facilitation of undergraduate nursing students: The perspectives of clinical facilitators*. *Nurse education in practice* (Doctoral dissertation, Griffith University, Brisbane, QLD). Retrieved from <https://research-repository.griffith.edu.au/handle/10072/365929>
- Needham, J., McMurray, A., & Shaban, R. Z. (2016). Best practice in clinical facilitation of undergraduate nursing students. *Nurse Education in Practice*, 20, 131–138. <https://doi.org/10.1016/j.nepr.2016.08.003>
- New South Wales Department of Health. (2011). *Ways of working in nursing: Resource package*. Sydney, NSW: Author. Retrieved from

<https://www.health.nsw.gov.au/nursing/projects/Publications/ways-of-working.pdf>

Nursing and Midwifery Board of Australia. (2006). *National Competency Standards for the Registered Nurse*. Melbourne, VIC: Author. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>

Nursing and Midwifery Board of Australia. (2007). *A National Framework for the Development of Decision-making Tools for Nursing and Midwifery Practice*. NMBA. Melbourne, VIC: Author. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx>

Nursing and Midwifery Board of Australia. (2015). *Framework for Assessing Standards for Practice for Registered Nurses, Enrolled Nurses and Midwives*. NMBA. Melbourne, VIC: Author. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx>

Nursing and Midwifery Board of Australia. (2016). *Registered Nurse Standards for Practice*. Retrieved from <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>

Nursing and Midwifery Board of Australia. (2017). *Code of conduct for nurses*. Retrieved from <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>

O'Driscoll, M. F., Allan, H. T., & Smith, P. A.. (2010). Still looking for leadership – Who is responsible for student nurses' learning in practice? *Journal of Nursing*

- Scholarship*, 33(1), 93–96. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/20172633>
- Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in qualitative research. *Journal of Nursing Scholarship*, 33(1), 93–96. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/11253591>
- Pandey, S. C., & Patnaik, S. (2014). Establishing reliability and validity in qualitative inquiry: A critical examination. *Journal of Development & Management Studies*, 12(1), 5743–5753. Retrieved from http://www.researchgate.net/profile/Satyendra_Pandey2/publication/266676584_ESTABLISHING_RELIABILITY_AND_VALIDITY_IN_QUALITATIVE_INQUIRY_A_CRITICAL_EXAMINATION/links/543779b40cf2dc341db4d7fb.pdf
- Parsons, K. (2010). Exploring how Heideggerian philosophy underpins phenomenological research. *Nurse Researcher*, 17(4), 60–69. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/20712235>
- Patterson, E. E. B., Boyd, L., & Mnatzaganian, G. (2017). The impact of undergraduate clinical teaching models on the perceptions of work-readiness among new graduate nurses: A cross sectional study. *Nurse Education Today*, 55(August 2016), 101–106. <https://doi.org/10.1016/j.nedt.2017.05.010>
- Patton, M. (1987). *How to use qualitative methods in evaluation*. Newbury Park, CA: Sage.
- Patton, M. (1990). Designing qualitative studies. In *Qualitative research and evaluation methods*. (2nd ed., pp. 169-186). Beverly Hills, CA: Sage. Retrieved from <http://legacy.oise.utoronto.ca/research/field-centres/ross/ctl1014/Patton1990.pdf>

- Patton, M. (2015). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Pope, C., & Mays, N. (1995). Qualitative research: Reaching the parts other methods cannot reach—an introduction to qualitative methods in health and health services research. *BMJ*, *311*(July), 42–45. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2550091/pdf/bmj00599-0046.pdf>
- Price, L., Hastie, L., Duffy, K., Ness, V., & McCallum, J. (2011). Supporting students in clinical practice: Pre-registration nursing students' views on the role of the lecturer. *Nurse Education Today*, *31*(8), 780–784. <https://doi.org/10.1016/j.nedt.2011.04.009>
- Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: A discussion and critique. *Nurse Researcher*, *18*(3), 20–24. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/21560922>
- Punch, K. F. (2014). Theory and method in social science research. *Introduction to social research: Quantitative & qualitative approaches* (3rd ed.). London: Sage.
- QSR International. (2010). NVivo 10 [Computer software]. Retrieved from <https://www.qsrinternational.com>
- Ramosaj, B., & Berisha, G. (2014). Systems theory and systems approach to leadership. *Iliria International Review*, *4*(1), 59-76. <https://doi.org/10.21113/iir.v4i1.53>

- Reid-Searl, K., & Happell, B. (2011). Factors influencing the supervision of nursing students administering medication: The registered nurse perspective. *Collegian*, 18(4), 139–146. <https://doi.org/10.1016/j.colegn.2011.05.003>
- Reid-Searl, K., & Happell, B. (2012). Supervising nursing students administering medication: A perspective from registered nurse. *Journal of Clinical Nursing*, 21(13–14), 1998–2005. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/22384822>
- Reid-Searl, K., & Happell, B. (2010). Nursing students administering medication: Appreciating and seeking appropriate supervision. *Journal of Advanced Nursing*, 66(3), 532–541. <https://doi.org/10.1111/j.1365-2648.2009.05214.x>
- Reid-Searl, K., Happell, B., Burke, K. J., & Gaskin, C. J. (2013). Nursing students and the supervision of medication administration. *Collegian*, 20(2), 109–114. <https://doi.org/10.1016/j.colegn.2012.04.003>
- Reid-Searl, K., Moxham, L., Walker, S., & Happell, B. (2009). Internal conflict: Undergraduate nursing students' response to inadequate supervision during the administration of medication. *Collegian*, 16(2), 71–77. <https://doi.org/10.1016/j.colegn.2008.11.002>
- Reiners, G. M. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing & Care*, 1(5), 1–3. <https://doi.org/10.4172/2167-1168.1000119>
- Russell, C., & Gregory, D. (2003). EBN users' guide to evaluation of qualitative research studies. *Evidence-based Nursing*, 6(April), 36–40. <https://doi.org/10.1136/ebn.6.2.36>
- Russell, K., Hobson, A., & Watts, R. (2010). The team leader model: An alternative to preceptorship. *Australian Journal of Advanced Nursing*, 28(3), 5–13.

- Russell, K. P. (2013). *The Art of Clinical Supervision Program for Registered Nurses* (Doctoral dissertation, Notre Dame University, Fremantle, WA). Retrieved from <https://researchonline.nd.edu.au/cgi/viewcontent.cgi?article=1084&context=theses>
- Ryan, C., & McAllister, M. (2017). Enrolled nurses' experiences learning the nurse preceptor role: A qualitative evaluation. *Collegian*, 24(3), 267–273. <https://doi.org/10.1016/j.colegn.2016.04.001>
- Ryan, F., Coughlan, M., & Cronin, P. (2007). Step-by-step guide to critiquing research. Part 2: Qualitative research. *British Journal of Nursing*, 16(12), 738–744. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/17851363>
- Salamonson, Y., Everett, B., Halcomb, E., Hutchinson, M., & Jackson, D. (2015). Unravelling the complexities of nursing students' feedback on the clinical learning environment: A mixed methods approach. *Nurse Education Today*, 35(1), 206–211. <https://doi.org/10.1016/j.nedt.2014.08.005>
- San Miguel, C., & Rogan, F. (2015). Assessing students' English language proficiency during clinical placement: A qualitative evaluation of a language framework. *Nurse Education Today*, 35(6), 771–776. <https://doi.org/10.1016/j.nedt.2015.02.014>
- School of Nursing and Midwifery Faculty of Health. (2009). *Clinical reasoning: Instructor resources*. Retrieved from https://www.newcastle.edu.au/_data/assets/pdf_file/0010/86536/Clinical-Reasoning-Instructor-Resources.pdf
- Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientifici

- interpretive, and critical research paradigms. *English Language Teaching*, 5(9), 9–16. <https://doi.org/10.5539/elt.v5n9p9>
- Sedgewick, M. & Harris, S. (2012). A critique of the undergraduate nursing preceptorship model. *Nursing Research and Practice*, 2012, 1-6. doi: 10.1155/20120248356
- Shahsavari, H., Parsa Yekta, Z., Houser, M. L., & Ghiyasvandian, S. (2013). Perceived clinical constraints in the nurse student-instructor interactions: A qualitative study. *Nurse Education in Practice*, 13(6), 546–552. <https://doi.org/10.1016/j.nepr.2013.05.006>
- Sharma, G. (2017). Pros and cons of different sampling techniques. *International Journal of Applied Research*, 3(7), 749–752. Retrieved from <http://www.allresearchjournal.com/archives/2017/vol3issue7/PartK/3-7-69-542.pdf>
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2004), 63–75. Retrieved from <https://pdfs.semanticscholar.org/cbe6/70d35e449ceed731466c316cd273032b28ca.pdf>
- Sherman, R. O., & Eggenberger, T. (2008). Transitioning internationally recruited nurses into clinical settings. *Journal of Continuing Education in Nursing*, 39(12), 535–544. Retrieved from https://www.researchgate.net/publication/23707403_Transitioning_Internationally_Recruited_Nurses_Into_Clinical_Settings
- Sifers, S. K., Puddy, R. W., Warren, J. S., & Roberts, M. C. (2002). Reporting of demographics, methodology, and ethical procedures in journals in pediatric

- and child psychology. *Journal of Pediatric Psychology*, 27(1), 19–25.
<https://doi.org/10.1093/jpepsy/27.1.19>
- Skingley, A., Arnott, J., Greaves, J., & Nabb, J. (2007). Supporting practice teachers to identify failing students. *British Journal of Community Nursing*, 12(1), 28–32. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/17353809>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, UK: Sage.
- Smith, J. A., & Osborn, M. (2007). *Interpretative phenomenological analysis. Qualitative psychology* (8th ed.). London, UK: Sage.
- Smythe, E. A., Ironside, P. M., Sims, S. L., Swenson, M. M., & Spence, D. G. (2008). Doing Heideggerian hermeneutic research: A discussion paper. *International Journal of Nursing Studies*, 45(9), 1389–1397.
<https://doi.org/10.1016/j.ijnurstu.2007.09.005>
- Speziale, H. S., & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia: Lippincott Williams and Wilkins.
- Spouse, J. (2001). Bridging theory and practice in the supervisory relationship: A sociocultural perspective. *Journal of Advanced Nursing* 33(4), 512–522.
<https://www.ncbi.nlm.nih.gov/pubmed/11251739>
- Taylor, C. (1989). *Sources of the self: The making of the modern identity*. Cambridge, MA: Harvard University Press.
- Taylor, C. (1993). Engaged agency and background in Heidegger. In C. Guigon (Ed.), *The Cambridge companion to Heidegger* (pp. 317–336). Cambridge, MA: Harvard University Press.

- Terry, K. (2013). *The competency landscape: A critical realist exploration of the ways nurses understand and utilise competency standards* (PhD thesis, University of Tasmania, Hobart, TAS). Retrieved from <https://eprints.utas.edu.au/17166/>
- Terry, K., Stirling, C., Bull, R., & Fassett, D. (2017). An overview of the ways nurses understand and utilise the existing Australian competency standards for registered nurses. *Collegian*, 24(2), 109–116. <https://doi.org/10.1016/j.colegn.2015.10.003>
- Tertiary Education Commission. (1978). *Nurse education and training: Report of the Committee of Inquiry into Nurse Education and Training to the Tertiary Education Commission*. Committee on Nurse Education and Training. Canberra, ACT: Author. Retrieved from <http://www.voced.edu.au/content/ngv%3A35641>
- Thomas, G. (2008). Dimensions of facilitator education. In S. Schuman (Ed.), *AF handbook of group facilitation: Best practices from the leading organization in facilitation* (pp. 181–192). San Francisco, CA: Jossey-Bass. Retrieved from <https://www.nationalcollege.org.uk/cm-mc-ad-fac-resource-extract-dimensions.pdf>
- Thomas, P. Y. (2010). *Towards developing a web-based blended learning environment at the University of Botswana* (Doctoral dissertation, University of South Africa, Pretoria, South Africa). Retrieved from <http://hdl.handle.net/10500/4245>
- Tobin, G. A., Begley, C. M., & Tobin, G. (2004). Methodological rigour within a qualitative framework. *Methodological Issues in Nursing Research*, 48(4), 388–396. Retrieved from

<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.136.7778&rep=rep1&type=pdf>

- Tufford, L., & Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80–96. <https://doi.org/10.1177/1473325010368316>
- Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *Qualitative Report, 15*(3), 754–760. Retrieved from <http://nsuworks.nova.edu/cgi/viewcontent.cgi?article=1178&context=tqr>
- Vandermause, R., & Fleming, S. E. (2011). Philosophical hermeneutic interviewing. *International Journal of Qualitative Methods, 10*(4), 367–377. Retrieved from <http://ejournals.library.ualberta.ca/index.php/IJQM/article/view/9502/9360>
- Verhonick, P., & Seaman, C. (1982). *Research methods for undergraduate students of nursing* (2nd ed.). New York, NY: Appleton-Century-Crofts.
- Volpe, R. L. (2011). *Moral distress, cynicism and internalisation of values in nurses*. (PhD dissertation, Saint Louis University, MO). Retrieved from <https://library.parker.edu/eds/detail?db=ccm&an=109855144&isbn+9781124540566>
- Von Bertalanffy, L. (1968). *General system theory* (Vol. 1). New York, NY: George Braziller. Retrieved from https://monoskop.org/images/7/77/Von_Bertalanffy_Ludwig_General_System_Theory_1968.pdf
- Walker, A., Storey, K. M., Costa, B. M., & Leung, R. K. (2015). Refinement and validation of the Work Readiness Scale for graduate nurses. *Nursing Outlook, 63*(6), 632–638. <https://doi.org/10.1016/j.outlook.2015.06.001>

- Walker, A., Yong, M., Pang, L., Fullarton, C., Costa, B., & Dunning, A. M. T. (2013). Work readiness of graduate health professionals. *Nurse Education Today*, 33(2), 116–122. <https://doi.org/10.1016/j.nedt.2012.01.007>
- Walker, S., Dwyer, T., Moxham, L., Broadbent, M., & Sander, T. (2013). Facilitator versus preceptor: Which offers the best support to undergraduate nursing students? *Nurse Education Today*, 33(5), 530–535. <https://doi.org/10.1016/j.nedt.2011.12.005>
- Walker, W. (2011). Hermeneutic inquiry: Insights into the process of interviewing. *Nurse Researcher*, 18(2), 19–27.
- Western Australia Department of Health. (2016). *WA health clinical risk management guidelines: A best practice guide*. Perth, WA: Author. Retrieved from http://ww2.health.wa.gov.au/~media/Files/Corporate/general/documents/Quality/PDF/WA_Health_Clinical_Risk_Management_Guidelines.ashx
- Wheeler, M. (2011). *Martin Heidegger*. Retrieved from <https://plato.stanford.edu/archives/win2016/entries/heidegger/#Be>
- Whitehead, L. (2004). Enhancing the quality of hermeneutic research: Decision trail. *Journal of Advanced Nursing*, 45(5), 512–518. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/15009354>
- World Health Organization. (2016). *Nurse educator core competencies*. Retrieved from http://who.int/hrh/nursing_midwifery/nurse_educator050416.pdf
- Wildridge, V., & Bell, L. (2002). How CLIP became ECLIPSE: A mnemonic to assist in searching for health policy/management information. *Health Information & Libraries Journal*, 2, 113–115. <https://doi.org/10.1046/j.1471-1842.2002.00378.x>

- Wolff, A. C., Pesut, B., Regan, S., & Black, J. (2010). Ready for what? An exploration of the meaning of new graduate nurses' readiness for practice. *International Journal of Nursing Scholarship*, 7(1), 1–14. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/20196766>
- Woods, C., West, C., Mills, J., Park, T., Southern, J., & Usher, K. (2015). Undergraduate student nurses' self-reported preparedness for practice. *Collegian*, 22(4), 359–368. <https://doi.org/10.1016/j.colegn.2014.05.003>
- Zasadny, M. F., & Bull, R. M. (2015). Assessing competence in undergraduate nursing students: The Amalgamated Students Assessment in Practice model. *Nurse Education in Practice*, 15, 126–133. <https://doi.org/10.1016/j.nepr.2015.01.003>
- Zilembo, M. (2008). *A descriptive survey of undergraduate nursing students' perceptions of desirable leadership qualities of nurse preceptors* (Honour's thesis, Edith Cowan University, Perth, WA). Retrieved from http://ro.ecu.edu.au/theses_hons/1117
- Zilembo, M., & Monterosso, L. (2008). Towards a conceptual framework for preceptorship in the clinical education of undergraduate nursing students. *Contemporary Nurse*, 30(1), 89–94. <https://www.ncbi.nlm.nih.gov/pubmed/19072195>

Appendix A: Heidegger's Threefold Structure of Interpretation: The Structure of Understanding

Permission Not Obtained for Appendix A

Appendix A obtained from Conroy (2003, Appendix A, p. 40)

Figure Originally developed by Conroy (2001, Figure adapted from Dreyfus, 1991. pp.198-199).

Conroy, S. A. (2001). Moral inclinations of medical, nursing, and physiotherapy students. Unpublished doctoral dissertation, University of Oxford, Oxford.

Reprinted from Conroy (2001, adapted from Dreyfus, 1991, pp. 198–199).

Appendix B: Participant Information Sheet



INFORMATION SHEET

The lived experience of how clinical educators identify, assess and manage risk to final semester nursing students' preparedness within the health setting.

You are invited to participate in this project, which is being conducted as part of the requirements of a unit. Details about the unit are given below:

Unit Code: RM6102
Unit Name: Ethics for Professional Practice
Unit Coordinator: Marc Fellman
School: Nursing and Midwifery

The purpose of the project is to explore your experience in identifying, assessing and managing final semester nursing students whom you have considered to be at risk. We want to know how you do this and what factors within the health setting and the student facilitate or create barriers in your supervision of struggling students.

If you choose to participate in this project you will be asked to:

- Participate in two interviews
- Once your data is transcribed and themed by the researcher, you will be asked to review this with the researcher in the second interview.
- Both the first and second interview will be erased at the completion of the unit
- Data collection, analysis and reporting of the findings is expected to be finalized by July 2015.
- Although it is likely that you will not be adversely impacted by these interviews, there may be minor discomfort associated with this study. A counsellor from Notre dame university will be available should you need to refer to a professional for advice.

The information will be used to complete the requirements for the unit noted above, and only the unit coordinator will have access to the information. Any information or details will be kept confidential and will only be used for the purposes of this project. You will not be identified in any written assignment or presentation of the results of this project. Participation in this project is voluntary. If you choose to participate, you are free to withdraw from further participation at any time without giving a reason and with no negative consequences. You are also free to ask for any information which identifies you to be withdrawn from the study.

If you have any questions or require any further information about the project, please contact:

Unit co-ordinator
Dr Marc Felman
marc.fellman@nd.edu.au
Phone 9433 0942

Researcher
Rosealie Southwell
r.southwell@nd.edu.au
Phone 0417 004 174

The Unit co-ordinator is responsible for the ethical conduct of this project. However, if you have any concerns and complaints about the project and wish to speak to an independent person, you may the Ethics Officer, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au

Appendix C: Plain Language Statement

PROJECT TITLE: The lived experience of clinical facilitators in dealing with risk to final semester nursing student's readiness for the role of RN within Western Australian health settings

CHIEF INVESTIGATOR: Selma Allieux

STUDENT RESEARCHER: Rosealie Southwell

STUDENT'S DEGREE: MPhil Nursing

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

The research project investigates how clinical facilitators I, A & M final semester nursing students who are struggling in the clinical placement. Students may be motivated to learn but factors within both themselves and the clinical placement may hinder or assist the student in obtaining learning opportunities. As you regularly identify students who are at risk and provide ways for them to reach their learning objectives you are invited to participate in this research project.

The purpose of the study is to explore the experience of clinical facilitators through in-depth interviews of how they I, A & M these factors. It is anticipated that the knowledge that will arise from the investigation will give greater insight into how clinical facilitators might be better supported to manage this aspect of student supervision

There are two questions that the researcher proposes to explore:

What are Clinical Facilitators' perceptions of the factors that may impact on the final semester nursing student's ability to be ready for the role of the RN?

How do Clinical Facilitators I, A & M perceived factors that hinder final semester nursing student's ability to be ready for the role of the RN?

This is potentially significant not only for clinical facilitators, but also for students, clinical placement staff and higher education providers. It is anticipated that this study will highlight how clinical facilitators perceive they are able to I, A & M risk, and what do they perceive to be the barriers and enablers in identifying, assessing and managing students at risk. This study may reveal how these factors will need to be reviewed in light of an understaffed, demanding and complex environment so that better systems and support are provided for students and for clinical facilitators.

Who is undertaking the project?

This project is being conducted by Rosealie Southwell and will form the basis for the degree of Master of Philosophy in Nursing at The University of Notre Dame Australia, under the supervision of Dr. Selma Allieux and Dr. Kylie Russell.

What will I be asked to do?

If you are willing to participate in two interviews, I will come to meet with you at a mutually agreed location. The times and dates will be arranged so that it is mutually convenient.

The time allocated for each interview is approximately 60 – 90 minutes.

Before the commencement of the first interview, you will have this information sheet explained to you. You will then be asked to sign a consent form to show that you have agreed to take part in the study.

Initially you will be asked about your working history as a clinical facilitator. This will be audio-taped and it will help me understand more about where you have worked and the type of students and type of health settings that you have worked in.

You will be asked to talk freely about your experiences supervising students during their final clinical placement. My role is to be an active listener and I will encourage you to expand on your experience so that I fully understand what this means to you. I may take some notes through the interview to help me with my interview process.

At the completion of the interview, you will be asked to complete a short questionnaire that relates to demographic information. This demographic questionnaire is attached for your perusal.

A second interview will be undertaken by telephone or face to face at a mutually agreed location and date that is convenient to you. I will contact you at a later date to arrange this meeting. The second interview is to focus on areas of the first interview that need further clarification. You may like to include any thoughts or further experiences that you may have forgotten to tell me. This is an important part of the research project as I want to ensure I have identified correctly what it means for you to facilitate the struggling student within the clinical placement. If needed, a third interview or follow up telephone conversation will be arranged.

Are there any risks associated with participating in this project?

There are no foreseeable risks, however it is recognized that when talking about your experiences you may have some emotions that may surface. Should this occur I will pause and give you time to adjust. You will have access at all times to turning the digital recording off and you may cease the interview at any time. With your permission I will reschedule another visit to complete the interview if needed. Should you require further support I will give you the names of appropriate contacts.

What are the benefits of the research project?

It is unlikely that you will gain personal benefit from participating in this research. However, the issues you identify and manage will reveal the extent of the issues you face in undertaking your role and may have a benefit long term. The benefits long term may provide a platform for giving other clinical educators greater insight into how to navigate the interplay between student factors and a highly complex working environment. It may inform researchers, higher education providers and clinical placement professionals of contributing factors that adversely impact upon students being prepared. It also may provide additional information to support Clinical Educators in identifying, assessing and managing students who may struggle.

Can I withdraw from the study?

Participation in this study is completely voluntary. You are not under any obligation to participate. If you agree to participate, you can withdraw from the study at any time without adverse consequences.

Will anyone else know the results of the project?

Information gathered about you will be held in strict confidence. This confidence will only be broken in instances of legal requirements such as court subpoenas, freedom of

information requests, or mandated reporting by some professionals. As a small sample size is required for this study there may be implications for protecting your identity, however, every step to protect your identity is being undertaken. Your data is de-identified as each participant is given a code number and a pseudonym. All the information will be stored in a locked filing cabinet and on a password protected computer in an area that is locked when not occupied. All transcribed data and audio taping will be erased on completion of the study. You will not be identifiable in any publication of research findings. All data will be stored securely in the School of Nursing and Midwifery at The University of Notre Dame Australia for a period of five years. The study will be published in a high impact journal or a journal of nursing education. The study will also be presented at conferences.

Will I be able to find out the results of the project?

At the final interview, you will be offered the opportunity to have a summary of the findings at the conclusion of the study. Should you wish to have this, I will email or post a copy to you.

Who do I contact if I have questions about the project?

If you wish to discuss any matter related to the research project you are invited to liaise with me or my supervisors. Questions may be given at any time during or after the research project is completed. To contact the researcher or the supervisor, please correspond with them by letter, email or telephone.

What if I have a complaint or any concerns?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 014109F). If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?

For participation please email me. I will bring a copy of the demographic questions and the consent form. By signing the consent form you agree to participate in the study. Please feel free to ask any other questions that you may have concerning the research investigation.

Yours sincerely,

Rosealie Southwell

Chief-investigator/ MPhil Student

School of Nursing and Midwifery
Fremantle Campus
r.southwell@nd.edu.au
Phone 0417 004 174

Principle Supervisor

Professor Selma Allix
Pro-vice Chancellor of Nursing and Midwifery
Fremantle Campus
Email: selma.allix@nd.edu.au
19 Mouat St

Secondary Research Supervisor

Doctor Kylie Russell
Fremantle Campus
Email: Kylie.russell@nd.edu.au
19 Mouat St
Phone +61894330563

Phone +61894330647

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au

Appendix D: Notre Dame Approvals



19 Mount Street (PO Box 1225)
Fremantle, Western Australia 6959
Telephone: +61 8 9433 0555
Facsimile: +61 8 9433 0544
Email: enquiries@nd.edu.au
Internet: www.nd.edu.au

ABN: 69 538 443 218
CRICOS PROVIDER CODE: 01032F

30 June 2014

Professor Selma Allix & Mrs Rosealie Southwell
Office of Deputy Vice Chancellor
The University of Notre Dame Australia
Fremantle Campus

Dear Selma and Rosealie,

Reference Number: 014109F

Project Title: "The lived experience of clinical facilitators in dealing with risk to final semester nursing student's readiness for the role of Registered Nurse within Western Australian health settings."

Your response to the conditions imposed by a sub-committee of the university's Human Research Ethics Committee, has been reviewed and based on the information provided has been assessed as meeting all the requirements as mentioned in *National Statement on Ethical Conduct in Human Research* (2007). Therefore, I am pleased to advise that ethical clearance has been granted for this proposed study.

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

A rectangular box with a blue border, used to redact the signature of Dr Natalie Giles.

Dr Natalie Giles
Research Ethics Officer
Research Office

cc: Dr Karen Clark-Burg, Acting Dean, School of Nursing & Midwifery;
A/Prof Caroline Bulsara, SRC Chair, School of Nursing & Midwifery.



19 Moust St (PO Box 1225) Fremantle WA 6959
+61 8 9433 0555 | enquiries@nd.edu.au

22 August 2014

Rosealie Southwell
278B Kiln Road
Karrakup WA 6122

Dear Rosealie

On behalf of the School of Nursing & Midwifery, I write to advise you of approval of your research proposal and full candidacy in your Masters studies.

The Research Office congratulates you on this achievement and wishes you well for your research program. Please do not hesitate to contact the Research Office or your Supervisor if you have any questions about your candidacy.

Yours sincerely



Professor Peta Sanderson
Pro Vice Chancellor – Research

cc. Dr Karen Clark-Burg, Acting Dean, School of Nursing & Midwifery
Assoc Prof Caroline Bulsara, Chair SRC
Prof Selma Allix, Supervisor
Dr Kylie Russell, Supervisor
Dr Julia Alessandrini, HDR Education Coordinator

Broome Campus 88 Ouy St (PO Box 2287) Broome WA 6725
Sydney Campus 140 Broadway (PO Box 944) NSW 2007



ABN 69 330 643 210 | CRICOS Provider Code: 01032F

nd.edu.au



19 Mout St (PO Box 1225) Fremantle WA 6950
+61 8 9433 0555 | enquiries@nd.edu.au

4 August 2016

Rosealie Southwell
278B Kiln Road
KARRAKUP WA 6122

Dear Rosealie,

I am pleased to advise you that your request to transfer from a Master of Philosophy degree to a Doctor of Nursing degree at the University of Notre Dame Australia has been approved.

You may find the comments from the reviewers helpful. Regarding the document that was provided to the reviewers; comments were as follows:

- It is far more descriptive than it is analytical. This may be a phase the writing is going through and the supervisor may require the student to remove a lot of the unnecessary description and replace it with argument. This is normal.
- At times there is far too much detail presented. Again, this is normal and usually the student will learn to strip out the unnecessary material. As researchers we read to inform us but then we realise that we don't actually have to put it in the thesis. A thesis is an argument not a blow by blow description.
- The literature review is a cross between a systematic review and a conventional literature review. At this stage it is not a good example of either and is descriptive rather than argumentative or analytical. Again, it could be a phase in the developmental process.

To confirm your acceptance, please complete the enclosed copy of the change of course form and return it to the Research Office via email: fremantle_research@nd.edu.au. Your new course code is 8301, Doctor of Nursing. The course regulations for the Doctor of Nursing degree are enclosed for your information. Please refer to section '3. Maximum and Minimum Duration' to calculate your thesis submission date.

I can advise that in 2016 the University is able to meet the tuition fees of higher degree by research students under the guidelines of the Commonwealth Research Training Scheme (RTS). The situation in relation to fees is reviewed annually, as research income is determined each year by Department of Education. Thus, the University cannot guarantee fee exemption for the duration of the degree.

I wish you every success in your Doctoral studies. Please feel free to contact the Research Office on 9433 0664 or by email to if you require any assistance fremantle_research@nd.edu.au.

Yours sincerely,



Professor Peta Sanderson
Pro Vice Chancellor International and Research

cc: Prof Elaine Pavlos, Co-Supervisor and Dean, School of Nursing and Midwifery
Prof Deima Allex, Principal Supervisor
Dr Kylie Russell, Co-Supervisor
Anita Zele, Senior Administrative Officer, School of Nursing and Midwifery
Dr Kate Howell, HDR Education Coordinator, Research Office
Lorraine Mayhew, Senior Administrative Officer, Research Office

Enc: Change of Course form
Doctor of Nursing course regulations

Broome Campus 88 Guy St (PO Box 2287) Broome WA 6725
Sydney Campus 140 Broadway (PO Box 944) NSW 2007



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Appendix E: Guide Sheet for Interview

Guide Sheet for Interview

Initial Question:

“Tell me about your experiences with supervising students in their final practicum.”

Guiding Questions:

In keeping with IP the guiding questions below can be shortened, modified or added to, to assist the researcher to explore participant’s experiences.

1. Can you share with me a situation where a student struggled?
2. What factors have you identified that adversely impact upon student progression?
3. What are the barriers and enablers for identifying, assessing and managing these risks
4. How have these factors impacted you in identifying, assessing and managing your students?
5. Can you tell me how these factors have impacted on your relationship with students or the clinical placement staff?

Appendix F: Demographic Data

Demographic Questions

Four demographic questions will be asked of participants at the conclusion of the interview.

1. Have you received training in how to supervise undergraduate nursing students?

Yes

No

2. How many final semester students do you supervise in a year?

1- 16 students per year

17-32 students per year

33-50 students per year

50 - 100 students per year

Greater than 100 students per year

3. How many years have you been in a Clinical Educator Role?

Less than 1 year

1-4 years

5 -9 years

10 plus years

4. Do you work as a RN in any other capacity outside of supervising nursing students?

Yes

No

If yes, what specialty do you work in?

Appendix G: Participant Consent Form

The lived experience of CFs in dealing with risk to final semester nursing student's readiness for the role of RN within Western Australian health settings

Informed Consent Form

I, *(participant's name)* _____ hereby agree to being a participant in the above project.

I have read and understood the Information Sheet about this project and any questions have been answered to my satisfaction.

I understand that I may withdraw from participating in the project at any time without prejudice.

I understand that if I consent to interviews, these will be digitally recorded. This is for the research student and for their supervisors and second readers. I understand that this will be converted into written text.

I understand that all information gathered by the researcher will be treated as strictly confidential, except in circumstances of legal requirements such as court subpoenas, freedom of information requests, or mandated reporting by some professionals.

I understand that for the purposes of this research I will not be identified in any results of this project. I understand that I will have a pseudonym to protect my identity.

I agree that any research data gathered from me for this study may be published provided that my name or any other identifying information is not disclosed.

I understand that the protocol adopted by The University of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to and relevant section of the Privacy Act are available at <http://www.nhmrc.gov.au/>

PARTICIPANT'S SIGNATURE:		DATE:	
---------------------------------	--	--------------	--

RESEARCHER'S FULL NAME:	ROSEALIE ANNE SOUTHWELL	DATE:	
RESEARCHER'S SIGNATURE:		DATE:	

The Unit co-ordinator is responsible for the ethical conduct of this project. However, if you have any concerns and complaints about the project and wish to speak to an independent person, you may the Ethics Officer, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au

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Date	01/01/1999	Publication Type	Book
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Instructor name	Selma Allix	Expected presentation date	2021-03-03

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Date	01/01/1995	End Page	67
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Instructor name	Dr. Rosalie Southwell	Expected presentation date	2021-03-01

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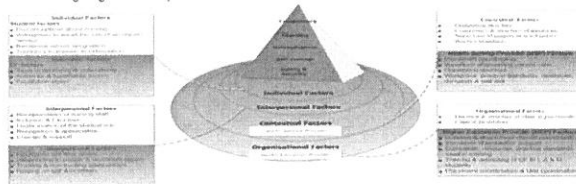
Levett-Jones (2007)

From: Rosealie Southwell <rosealie@drbobs.org>
Sent: Friday, 11 September 2020 2:26 PM
To: Tracy Levett-Jones <Tracy.Levett-Jones@uts.edu.au>
Subject: Permission request for

Hello Tracey,

I have followed your writing over the years and you have always been an inspiration to me. I have recently graduated and achieved a doctorate in nursing. I am writing to ask you for permission for me to publish and disseminate my findings alongside the use of your competency framework. The below figure is from my thesis and shows who I had amended yours. Figure 10.2 was on page 271 of your 2007 thesis - The Ascent to Competency conceptual framework situated within the complexity of the individual, interpersonal, contextual and organisational milieu

The following diagram was my amendment.



Thank you for your original framework and inspiration. I look forward to hearing back from you.

Kind Regards

Dr. Rosealie Southwell

From: Tracy Levett-Jones <Tracy.Levett-Jones@uts.edu.au>
Sent: Friday, 11 September 2020 12:47 PM
To: Rosealie Southwell <rosealie@drbobs.org>
Subject: RE: Permission request for

hi Rosalie

thank you for your kind words – they mean a lot.

Congratulations on your doctorate. It is such a wonderful achievement!

I am very happy for you to publish your findings (with acknowledgement) and to use the adapted framework (which is excellent BTW).

all the very best

Tracy Levett-Jones
Professor of Nursing Education
Head of School – Nursing & Midwifery

Faculty of Health | University of Technology Sydney
Room 234, Level 7, 235 Jones St, Ultimo NSW 2007
E tracy.levett-jones@uts.edu.au
W <https://discover-research.uts.edu.au/Tracy.Levett-Jones/about>
Zoom - <https://utsmeet.zoom.us/j/5757332824>
T +61 2 9514 5228

Western Australian Department of Health (2016)

To 'rosealie@drbobs.org'
Cc WA Health Enquiries; PSSU

Dear Rosalie,

Your enquiry has been passed on to us at the Patient Safety Surveillance Unit as custodians of this Clinical Risk document. We are pleased to grant you permission to utilise the diagrams as requested. Thank you also for the acknowledgment of this work.

Regards,
Karen

Karen Lennon
Manager | Patient Safety Surveillance Unit | Office of Patient Safety & Clinical Quality
Clinical Excellence Division | **Department of Health**
Level 3, GPO Building, 3 Forrest Place, PERTH, WA, 6000
T: +61 8 6373 2310 E: karen.lennon@health.wa.gov.au
www.health.wa.gov.au

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12 Feb 2021 7:27:27 AM, by Craig Myles

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26 Jan 2021 6:41:51 PM, by Rosealie Southwell

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