Best practice in clinical facilitation of undergraduate nursing students: The perspectives of clinical facilitators.

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Abstract

Background

This study sought to investigate what constituted best practice in clinical facilitation of undergraduate nursing students from the perspectives of those who undertake this role in health care agencies. Understanding clinical facilitation is important for maintaining quality of care, staff and student retention with an emphasis on employment and educational practices. The clinical facilitators reflected on their role highlighting aspects of the role and influences that either help or hinder them in achieving best practice. The study is important and unique educationally because what constitutes best practice in clinical facilitation can potentially inform both educational and management strategies for clinical facilitation. Importantly, this knowledge could strengthen opportunities for recruitment and retention of these members of the nursing workforce.

Methods

A case study using an interpretive, naturalistic approach was conducted to identify best practice in clinical facilitation of undergraduate nursing students from the clinical facilitators’ perspective. Data included focus group discussions, individual interviews and concept maps produced by focus group participants. Participants were recruited from the Griffith University School of Nursing and Midwifery Clinical Facilitator Database with data collected at a time and place of mutual convenience. Thematic analysis, with constant comparison of focus group discussions, interview data and concept maps was used to identify three common themes and ten subthemes.

Findings

Analysis of the data from eleven clinical facilitators revealed three themes. Best practice was seen to involve: assessing, learning to facilitate and facilitating effectively. The main sources of knowledge for the role of clinical facilitator were experiential and the networking with other facilitators. They reported that their role required excellent communication and interaction skills. Barriers to best practice included professional isolation, lack of educational
foundations, lack of clear policies and guidelines and balancing professional loyalty. A provisional best practice clinical facilitation model was developed from the data that lends itself to empirical testing in future research studies.

Conclusions

The study identified a number of pertinent issues of interest to nursing educators and clinical managers. These experienced clinical facilitators reported a perception that their experiential knowledge as both a registered nurse and a clinical facilitator was critical to developing best practice. While the clinical facilitators were relatively autonomous they felt somewhat isolated and craved closer liaison with academic staff and feedback about their performance, in particular, in their assessment of students. They found the lack of research into their role frustrating, considering that it is often referred to as an important role, which led some to believe that the role was undervalued by both their educational and clinical partners. The study has confirmed that clinical facilitators make a significant contribution to the educational preparation of undergraduate student nurses, integrating theory with practice through the use of best practice. The thesis elaborates on their perceptions culminating with a set of recommendations for practice, education and further research.
# TABLE OF CONTENTS

Abstract .................................................................................................................................................. ii  
Statement of Originality ...................................................................................................................... vii  
Acknowledgements ............................................................................................................................... viii  
Definition of Terms ............................................................................................................................... x  

## CHAPTER 1: INTRODUCTION ........................................................................................................ 1

Introduction ........................................................................................................................................... 1  
Background and context of the study ................................................................................................. 1  
  History of nurse education in Australia .......................................................................................... 1  
  Nursing workforce shortages and the need for facilitators ......................................................... 7  
  The clinical facilitator and facilitation ......................................................................................... 8  
  Models of clinical facilitation ....................................................................................................... 13  
  Educational preparation for the role of facilitator .................................................................... 14  
  The challenges of facilitation ....................................................................................................... 15  
The research problem .......................................................................................................................... 17  
Purpose of the study ............................................................................................................................. 18  
Research question ............................................................................................................................... 18  
Assumptions ......................................................................................................................................... 19  
Significance of the research ............................................................................................................... 19  
Organisation of the thesis ................................................................................................................... 20  

## CHAPTER 2: REVIEW OF LITERATURE ...................................................................................... 21

Introduction ........................................................................................................................................... 21  
Search strategy ..................................................................................................................................... 21  
Research into the role of the clinical facilitator ................................................................................. 22  
  North American Research studies ............................................................................................... 22  
  Other international research into the clinical facilitator role ................................................... 27  
Educational preparation for the role of clinical facilitator ............................................................... 28  
  United Kingdom and Irish Research ......................................................................................... 28  
  Australian research ...................................................................................................................... 32  
Integrating theory and practice .......................................................................................................... 42  
Summary of literature ......................................................................................................................... 46
CHAPTER 3: METHODOLOGY and METHODS .................. 48

Introduction ........................................................................................................... 48
Interpretivism ........................................................................................................ 48
Conceptualizing the study ................................................................................... 49
The case study approach ..................................................................................... 52
The Role of the Researcher .................................................................................. 54
Method .................................................................................................................. 55
  Setting .................................................................................................................. 55
  Sample .................................................................................................................. 55
  Data collection ..................................................................................................... 56
  Data management ................................................................................................. 60
  Data analysis ........................................................................................................ 61
Ethics ..................................................................................................................... 63
Rigour ..................................................................................................................... 65
Summary ............................................................................................................... 66

CHAPTER 4: FINDINGS ................................................................................. 68

Introduction ........................................................................................................... 68
Assessing ................................................................................................................ 70
  Assessing general needs ..................................................................................... 70
  Assessing student specific needs ....................................................................... 71
  Assessing the local environment ....................................................................... 74
  Matching up ........................................................................................................ 75
Learning to facilitate ............................................................................................. 77
  Formal and informal preparation ......................................................................... 77
  Maintaining knowledge ....................................................................................... 79
  Networking and shared knowledge ................................................................... 80
Facilitating effectively ........................................................................................... 81
  Interacting and communicating effectively ..................................................... 82
  Being supported .................................................................................................. 85
Exemplars of best teaching practice: The uniqueness of clinical teaching ......... 87
Summary – What constitutes best practice clinical facilitation ......................... 93
Concept mapping .................................................................................................. 94
Interview analysis .................................................................................................. 96
Learning to facilitate ............................................................................................. 97
Networking .............................................................................................................. 99
Interacting and communicating effectively ......................................................... 101
Being supported .................................................................................................... 101
Summary .................................................................................................................. 104

CHAPTER 5: DISCUSSION AND CONCLUSIONS ............. 106

Introduction ........................................................................................................... 106
What constitutes best practice in clinical facilitation? .................................. 106
Clinical experience and knowledge ................................................................. 109
Effective communication and interactions ..................................................... 110
Personal and professional characteristics ....................................................... 112
Barriers and enablers to providing best practice ........................................... 113
Preparing for a best practice future: Lessons from the field ....................... 119
Reflection on practice as a basis for strengthening learning and teaching .... 121
Professional development for clinical facilitation ........................................... 122
Strengths and limitations of study ................................................................. 125
Recommendations for practice ....................................................................... 126
Recommendations for education .................................................................... 127
Recommendations for research ....................................................................... 128
Conclusion ........................................................................................................... 129

REFERENCES .................................................................................................... 130

Appendix A ........................................................................................................... 141
Appendix B ........................................................................................................... 142
Appendix C ........................................................................................................... 146
Appendix D ........................................................................................................... 149

List of Tables
Table 3 - 1 Data Sets ............................................................................................ 61
Table 4 - 1 Participant demographics (N=11) .................................................... 69
Table 4 - 2 Themes and sub-themes ................................................................. 70

List of Figures
Figure 4 - 1 Best practice in clinical facilitation model. ................................. 104
Statement of Originality

The work in this thesis has not been previously submitted for a degree or diploma at any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Signed

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Date

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I dedicate this thesis to my dad, Thomas George Brooke, and my brother-in-law, Neville (Ross) Brown, who both instilled in others that you needed to work hard to fulfil your dreams.

The conduct and completion of this study would not have been possible without the significant support and guidance of many people.

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are registered nurses working in the role of clinical facilitators who have a genuine desire to work together to create better environments for student learning.
Definition of Terms

The following terms are used throughout the thesis.

Best Practice: a systematic approach to practice in any field, for example, education / nursing, where a standard way of doing things are developed and can be based on self-assessment or benchmarking (Bogan & English, 1994).

Facilitation: a process of one person assisting others to make something easier where participants work together, setting and achieving goals that maintain mutual respect, in order to learn (Nash, 2007).

Clinical Facilitator: also known as a clinical teacher (Robertson, 1986) is a registered nurse who supervises student nurses while the undergraduates undertake their clinical placement. These RNs are usually employed on a sessional (casual) basis, are supernumerary and responsible for a group of usually 8 students (Health Workforce Australia, 2010; Nash, 2007).

Clinical Teacher: a person with direct, immediate responsibility that a student’s field experience leads to clinical competency (Napthine, 1996, p. 20).

Clinical Educator: A role that provides support to clinical supervisors and may involve day to day supervision of learners (Health Workforce Australia, 2010, p. 9). Sometimes called facilitators to support, teach and assess groups of students (Levett-Jones & Bourgeois, 2011).

Clinical Placement/practicum: placement in a hospital or other clinical health care setting for varying lengths of time, dependent on university curricula (Health Workforce Australia, 2010).

Practice Education Facilitator (PEF): The PEF role is to facilitate and support professional development of mentors, newly qualified nurses and other health care staff (Carlisle, Calman, & Ibbotson, 2009).

Registered Nurse – RN (Division 1): a nurse who has completed 3 - 4 years of education either through hospital training or via a tertiary degree called a Bachelor of Nursing and licensed to practise nursing by Australian Health Practitioner Registration Agency (AHPRA).
Preceptor: registered nurse who works every shift with one student and completes the formal clinical assessment of the allocated student (Health Workforce Australia, 2010).

Undergraduate Student Nurse: a person yet to qualify as a registered nurse, enrolled in a Bachelor of Nursing Program

Bachelor of Nursing Program: A baccalaureate level program accredited with the Australian Nursing and Midwifery Accreditation Council (ANMAC), undertaken within the university sector, (tertiary education). The program must be completed successfully to be eligible for registration as a Registered Nurse with AHPRA (Australian Nursing and Midwifery Accreditation Council, 2009).

Nursing Faculty; a registered nurse employed in a university academic role who holds at least a Bachelor of Nursing and teaches in the undergraduate Bachelor of Nursing Program (Knox & Mogan, 1985).

Buddy Nurse: a registered nurse who works with the student nurse in the clinical setting but does not complete formal clinical assessment (Brammer, 2006).

Supervision: guidance to students and ability to supply feedback to students including personal, professional and educational development while ensuring safe and high quality patient care (Kilminster, Cottrell, Grant, & Jolly, 2007). A supervisor’s main function would include ensuring that a group of subordinates completes the assigned amount of work, within acceptable levels including quality and safety.

Scope of Nursing Practice: The scope of nursing practice is that which nurses are educated, competent and authorized to perform (Levett-Jones & Bourgeois, 2011, p. 13).

Competency Standards: Are “standards that describe current practice of nurses” (National Nursing Organisation, 2004, p. 6). These practice standards must be achieved by those completing education in order to register as registered nurses (ie ANC National Competency Standards for the Registered Nurse and the Enrolled Nurse). The competency standards are used for
academic assessment, workplace performance review and for measuring continuing fitness to practise (National Nursing Organisation, 2004, p. 6).

Self-directed Learning: an approach to learning that relies heavily on students being responsible for, and possessing the ability to, initiate their own learning (Smedley, 2007, p. 373).

Experiential Learning: a process of learning that draws on experiences to reinforce theory and knowledge being taught, including learning through reflection (Smith, 2001).
CHAPTER 1: INTRODUCTION

Introduction

This study sought to explore what constituted best practice in clinical facilitation of undergraduate nursing students from the perspectives of those who undertake this role in health care agencies; clinical facilitators. The study is important and unique educationally because it identifies what constitutes best practice for clinical facilitation with an emphasis on employment and educational practices that have not been documented in the published literature. Identification of the elements of what constitutes best practice in clinical facilitation and the practices therein has the potential to inform both education and management strategies that may help improve recruitment and retention of this important component for the nursing workforce.

To examine clinical facilitation and the role of the clinical facilitator in undergraduate student placements within the Australian context, it was important first to describe the global context. The overview of the history of nursing that follows provides important background information related to the changes that have occurred within education and the supervisory models and thus clinical facilitation of undergraduate student nurses in Australia.

Background and context of the study

History of nurse education in Australia

Nursing in Australia, as a colony of England, has been influenced by the teachings of Florence Nightingale, who cared for soldiers during the Crimean War. Haunted by the suffering she had witnessed therein, she established the Nightingale School of Nursing at St Thomas’ Hospital, London in 1860 (Wood, 1990). This hospital, and the nursing training it provided, were acknowledged as the best in the world for its time (Kelly & Joel, 1996; Wood, 1990).
In Australia, when the First and Second Fleets arrived in 1788, untrained convicts who were usually convalescing themselves provided nursing care. The model of care was such that men predominantly cared for male patients and women cared for female patients (Bloomfield, 2009). Qualified naval surgeons who were responsible for, and therefore determined, the nurses’ roles, provided medical care. Other people who were sick were traditionally cared for at home by non-convict women; for example, mothers cared for their children. Lucy Osburn, a Nightingale graduate, and five other nurses arrived in Sydney in 1868 at the request from the then Colonial Secretary, Sir Henry Parkes (Godden, 2001). Osburn, a strong supporter of Nightingale, found conditions in the colony appalling, and she began a campaign to improve the professional image of nursing in Australia. She arranged for the colonial nurses, who were often females of convict origin and socially outcast, to be trained in hospital-based nursing schools (Bloomfield, 2009). At the time many of these Australian nurses were considered intellectually inferior as they were convicts and less able for more useful work (such as building or agriculture). Therefore, the government magistrates would sentence these convicts to nursing which was considered the only suitable occupation for them (Bloomfield, 2009). The nurses provided cheap labour, and they paid for the privilege of becoming a nurse by working in the hospital. In this system the needs of the hospital were prioritised over the needs of the nurse, particularly when it came to education. It was, in effect, a form of apprenticeship, which continued in Australia for over a hundred years (Wood, 1990).

During World War One, 95% of nurses were women. A key feature of the apprenticeship model during this time was that nursing practice and education was medically dominated, primarily by male doctors. The end of World War One brought changes to Australian nurse education that was no longer considered adequate given that health care technology was evolving and patients’ expectations were increasing (Wood, 1990). With the increase in technology nurses were expected to have greater scientific knowledge to practise in a therapeutic manner (Barnard, 2006). These increasing expectations were, however, met within a medically-dominated model where
the education nurses undertook was unilaterally determined by doctors. While doctors were moving toward evidence-based practice they did not expect nurses to base their practice on research evidence. This situation reflected the imbalance in the power between medical doctors and nurses. The general gender bias of the time continued and is visible in books such as *Nursing Rituals, Research and Rational Actions* where cartoons depict the male medical consultants as dominating with nurses on their knees before them (Walsh & Ford, 1989). This relationship was intimidating to nurses, who had not yet professionalised their practice. For many years nursing was considered a semi-professional career (Ghadrian, Salsali, & Cheraghi, 2014) because nursing continued to be considered female work, which was a barrier to professionalisation.

Gender issues persisted as an impediment to professionalization, which had serious implications for nursing education. Ghadrian et al. (2014) defines professionalisation as “a cyclical process, which includes mastery of knowledge, skilful action, and having professional ideology, measured by standards” (p. 8). None of these elements of professionalization were achieved in the context of gendered power relations. Australian nurses along with their international nursing counterparts struggled with feelings of inferiority generated by oppressive medical practitioners and other colleagues, up until the early 1980s (Bloomfield, 2009). As a consequence, nurses were largely non-assertive, submissive and dependent; often referred to as the doctors’ ‘hand maidens’ (Longhurst, 2001). Kelly and Joel (1996) and Wood (1990) suggest that this non-assertive behaviour was reinforced by senior RNs who were rigid and controlling of their juniors. The history of nurses struggling for autonomy therefore shows subjugation by both doctors (Montgomery, 1987) and senior nurses (Rowe & Sherlock, 2005).

Medical dominance of the nursing profession and their education feature in health care systems in Australia and around the world (Bloomfield, 2009; Heath, 2002; The Victorian Government, 2006). This medical dominance has, however, changed with the professionalisation of nursing and the changing scope of practice (Schmalenberg & Kramer, 2009). Such changes permeate both practice and education. In the twenty-first century,
nurses are engaged in more collegial relationships with medical practitioners in both providing care and research (Schmalenberg & Kramer, 2009). The changes also reflect a greater emphasis in healthcare on teamwork and interprofessional care as major elements of quality and safety. Feedback to teaching staff from current student nurses after their clinical placements in local health care agencies indicates that the students have acknowledged changes in professional relationships, including occasional invitations for them to join the doctors’ rounds with their buddy RN so that they are part of the team caring for the patients. To some extent, the improvements in role relations can be attributed to changes in nursing education (Stevens, 2013).

Educational models have been influential in changing professional practice. In 1975, the preparation of Australian registered nurses was transferred from the hospital-based vocational setting to tertiary or higher education institutions. This new model of education led to schools of nursing being established in many Australian universities and Colleges of Advanced Education (National Review of Nursing Education, 2001). Before the transfer to tertiary education, and up until the late 1980’s and early 90’s in some Australian jurisdictions, both registered nurses (Division 1) and enrolled nurses (Division 2) were educated in hospitals under an apprenticeship model, where the focus of their learning was predominantly practical. Their vocational or work-based learning was supported by didactic teaching of concepts, propositions and facts about nursing practice, which were conducted by nurse educators in designated schools of nursing within large teaching hospitals. Although there were hospital schools of nursing, which provided blocks of lectures to students, much of their practice was learnt on the job.

Gradually, hospital-based schools of nursing closed their doors, with the transfer to the tertiary education sector in Australia completed in 1993 (Wellard, Williams, & Bethune, 2000). The transition to a tertiary educational model led to registered nurse preparation moving from all in-hospital experience to being managed largely through university laboratory-simulated experiences. These experiences were interspersed with some experiences in hospital clinical areas, where students’ learning was facilitated by registered
nurses acting as clinical facilitators, many of whom had little formal educational preparation (Napthine, 1996). This separation of clinically-based and university-based teaching has led many nursing scholars since then to express concerns about the theory-practice gap, which refers to the disconnect between formal learning in the university and practical experience in clinical settings (Kramer, 1974). This theory-practice gap and the need to better integrate knowledge and skills is well documented as a serious issue for the nursing profession (Armitage & Burnard, 1991; Gibbons, 1982; Hart, 1985; Hewison & Wildman, 1996; Higginson, 2004; Landers, 2000; McCaugherty, 1991; Scully, 2011). Benner (1984) an eminent nursing scholar argued that it was a multidimensional issue, given that there is a difference between “theory for knowledge” and “theory for practice”. The suggestion is that some practical knowledge may elude scientific formulations theory for practice is where you know how to do something. Theory for knowledge is the knowing that something is done because of a scientific reason. More recently, Scully (2011) argued that an ongoing problem for the nursing profession and, in particular student nurses, is linking textbook descriptions of clinical situations and scenarios with the reality of clinical practice. In response to ongoing professional discussions of the theory-practice gap, two major outcomes have been achieved through education and by ANMAC accreditation of nursing programs: improvements to theoretical components of the Bachelor of Nursing curricula and the continuation of student clinical placements within health care agencies (Landers, 2000). Nonetheless, there remains a need for continuous improvement in education for nurses to become adequately prepared for contemporary practice to improve patient care. To assist with the connection of theory to practice in the clinical arena, the role of clinical facilitators has evolved. Despite considerable effort to update theoretical knowledge for practice there has been limited attention to how best to educate clinical facilitators who assist the students socialise into the workplace, assess the students’ clinical skills, act as role models within the clinical setting and bridge the gap between theory and practice (Napthine, 1996; Scully, 2011).
In Australia, the clinical facilitator’s role has attracted attention from regulatory bodies. With the transition of nursing education into the Australian higher education sector in the late 1980’s the then Australian jurisdiction registering authorities attempted to address the theory-practice gap by providing guidelines for the models of education, requirements for accreditation and the designated hours required for clinical practice for respective curricula (Wellard et al., 2000). However, there has been disparity across Australian jurisdictions with respect to clinical practice requirements across nursing degrees and in some areas there still is a disparity. However, with the establishment of the Australian Nursing and Midwifery Accreditation Council (ANMAC) (2009) as a national accrediting authority, there has been greater standardisation in nursing curriculum requirements (ANMAC, 2009, 2012). All curricula now include a minimum of 800 hours of clinical placement. These clinical placements are crucial requirements of the program, as they provide students with the opportunity to apply the theoretical and clinical components provided to them in lectures and laboratories at university in real settings while further developing and extending their knowledge through practical experience (Lambert & Glacken, 2005).

The environment of clinical facilitation is challenging. Some of the challenges include assessing and scaffolding student knowledge to ensure the student partakes in the best possible clinical placement for best practice, an issue addressed in the literature review to follow Chapter 2. The term best practice is used to reflect the goal of maintaining the highest quality experience; in other words, the best level of learning and practice from which to benchmark the process of facilitation in both the education and clinical settings. O’Dell and Grayson (1998) explain benchmarking as a process of identifying, understanding and adapting outstanding practice, which are the keys to the success of best practice.

The aim of best practice is to ensure that graduates are clinically ready for practice as registered nurses. Like university educators, clinical facilitators can assist this process by teaching towards the highest standard of practice possible. Within many Australian universities the term clinical
*facilitator* refers to registered nurses who supervise student nurses while they undertake their clinical placement (see definition of terms). Clinical facilitators therefore play an important role in assisting undergraduate student nurses to become competent and safe registered nurses. Their role is paramount in enhancing the students’ learning in the workplace (Lambert & Glacken, 2005), which is, in turn, crucial to the students being able to provide high quality, safe patient care as graduates. Addressing the effectiveness of clinical facilitation is particularly important in the current situation of workforce shortages to ensure that the workforce is sustained with well-educated graduates.

**Nursing workforce shortages and the need for facilitators**

Since late last century there has been global shortages of nurses, with the demand for registered nurses expected to increase into the foreseeable future (Health Workforce Australia, 2010; International Council of Nurses, 2006; Lisko & O’Dell, 2010). HWA projects a shortfall of 109,000 nurses in Australia by 2025 (Health Workforce Insights Issue 9, 2013). Population ageing is a factor that will sustain the global demand for nursing, because of their expected increase in health care needs. The ageing nursing workforce, where in Australia 21.6% of the nursing workforce is over aged 55, also underlines the need to recruit nurses to replace those who will retire in future (HWA, 2013). Moreover, the scope of the registered nurses practice is changing, particularly in the area of advanced practice nursing roles as other health professionals are unable to cope with increased demands, especially with current and future shortages of general practitioners (GPs) and other allied health professionals, particularly in rural areas (HWA, 2011, 2013). HWA has identified the extent of health workforce shortages, and like a number of researchers, has forecasted potential shortages of experienced registered nurses who are well qualified to fulfill the role of clinical facilitator (Lisko & O’Dell, 2010). Addressing these shortages is critical to increasing university places in nursing to ensure an adequate workforce. The previous Australian government agenda has been to ensure that attending university is equitable to all, which has increased the number of lower socio-economic
students attending university, some of whom are first in family attendees, migrant students and/or women (Bradley, 2008). As long as this agenda to increase student numbers within university and in particular nursing courses continues then there will be a need for well-trained clinical facilitators.

High quality patient care requires high quality education that adequately integrates university curricula with the clinical practice setting. Likewise, it is imperative that the facilitation of clinical education meets the goals of accredited educational programs, which are aimed at maintaining educational integrity and best-practice based on sound pedagogical principles and evidence. Research into clinical facilitation is in its early stages, with limited published research exploring the perspectives of the clinical facilitator about best practice of clinical facilitation of undergraduate student nurses (Health Workforce Australia, 2010; Lee, Cholowski, & Williams, 2002). Experienced clinical facilitators’ views are critical to ongoing evaluation of the educational program as well as maintaining educational integrity. This study was therefore designed to address the gap in research knowledge by investigating the perceptions of best practice in clinical facilitation from those who undertake the role. Understanding the current realities of clinical facilitation practice will help inform educational strategies to ensure consistent, high quality standards of learning and clinical performance.

The clinical facilitator and facilitation

The published literature reveals ambiguity around the role and definition of the clinical facilitator, with many interchangeable terms used to describe the role (Henderson, Forrester, & Heel, 2006). Researchers variously describe clinical facilitation, clinical supervisors, their function and core skills of their practice (HWA, 2010). Generally speaking, a clinical facilitator is a registered nurse (RN) employed to facilitate learning and integrate theory and knowledge taught at university, assisting the student nurse to plan and achieve expected goals while undertaking their clinical placement (Levett-Jones & Bourgeois, 2011). Facilitation is “the act or
process of facilitating which is to make something easier or less difficult” (The Macquarie Dictionary, 1987, p. 629). This role is distinct from supervision, which is “the act or function of supervising” which is to “oversee (a process, work, workers, etc.) during execution or performance” (The Macquarie Dictionary, 1987, p. 1704). The terms clinical teacher, clinical educator, fieldwork supervisor and practice educator are all used interchangeably with clinical facilitator in the health literature (HWA, 2010). Within the discipline of nursing, the terms clinical facilitator, preceptor, practice partner, buddy, mentor and educator are predominantly used, depending on the model of clinical placement (see definition of terms) (Brammer, 2006; Henderson et al., 2010; Wellard et al., 2000). For this study the terms all refer to registered nurses who work with students in various situations. The role of the facilitator does, however, differ from that of the practice partner or buddy nurse in that the clinical facilitator undertakes supervision, assessment and remediation of the students’ clinical skills (Henderson et al., 2010; Nash, Sacre, Lock, & Ross, 2011), while the buddy nurse works alongside the student (Brammer, 2006). Some of the general qualities of facilitators suggested by the Academic Leadership for Course Coordinators Program include: good listening skills, relevant knowledge and experience of teaching and learning and organisational skills (Flavell, Jones, Ladyshewsky, & Oliver, 2009).

For this study the terms clinical facilitator and clinical facilitation were the focus. The objective of facilitation is to ensure that the care provided to patients by undergraduate student nurses is safe and of a quality to prevent harm to the patients (Kilminster et al., 2007). A clinical facilitator in this study denotes a registered nurse whose role is to facilitate a group of undergraduate student nurses to assist them negotiate a successful clinical placement and to evaluate the students’ progress (HWA, 2010).

Although there is a growing body of literature concerning clinical supervision, mentorship and preceptorship, there are few studies into clinical facilitation. One reason for this lack of research is the need for clarity around governance of clinical facilitation processes. Governance is a systematic approach to improve and maintain quality in health care (Levett-Jones & Bourgeois, 2011; Sorensen & Iedema, 2008). The governance of clinical
facilitation is challenging (Cleary, Horsfall, & Happell, 2010), because the role may have different understandings by the health care agency staff and university staff. Therefore, it is important to clarify the concept of facilitation and the role that it plays in the undergraduate students’ support while they are on clinical placement.

To date there are few published guidelines for clinical facilitation of undergraduate student nurses (HWA, 2010). Graduate registered nurses require supervision and guidance when first employed as do staff working in new and unfamiliar areas. There are guidelines for clinical supervision of staff who are already registered and working in ward areas. Bush (2005) suggests that clinical supervision is or aims to:

“support nurses; provide relief from the emotional and personal stress involved in nursing; help nurses work in an effective way; help nurses gain information and insights and develop and make the best of their work; encourage professional growth; be a part of lifelong learning; be a component of clinical governance; be an aid to improving quality of nursing care and be for nurses about nurses”.

p.41

Bush also explained what supervision is not. It is not “a management tool; a method of surveillance; a formal performance review; a form of preceptorship; counselling; hierarchical; a form of therapy or a criticism of the individual as a nurse or a person” (Bush, 2005, p. 40). While his paper outlines what he considers clinical supervision is and what it is not, his conclusions have not been informed by research evidence and the paper does not consider the role of a clinical facilitator in relation to supervision of student learning. Forsyth (2009) considered the role as “encompassing other supportive features including career advice” (p. 196). A supportive supervisor is a person who facilitates the socialisation of the undergraduate students into the ward environment (Dickerson, 2003; Forsyth, 2009). With increased clinical facilitation there is a need to ensure the quality of this important aspect of nursing education. In response to the need for quality and integrity of the clinical program for nurses and other health professionals HWA developed the Clinical Supervision Support Program (CSSP) (Health
Workforce Australia, 2010). This program considers capacity and competency of clinical supervisors and outlines the functions of clinical facilitators according to current practice (HWA, 2010). The CSSP covers allied health, dental, medicine, nursing and midwifery, all of which are included in ongoing professional discussions about developing a clinical supervision support framework.

Three main functions of supervisors identified by Forsyth (2009) were educational, supportive and managerial or administrative. The educational function suggests that the facilitator links the theoretical component of education to the practical setting where undergraduates practise their skills in a real environment (Gould, 2007). The supportive function of the role allows the supervisor to provide guidance and constructive feedback and to provide encouragement to the student in their practice. The managerial or administrative function offers the supervisee career guidance and assistance to set learning goals to ensure that the learning experience is positive (Forsyth, 2009). Linking theory to practice in the workplace, in the instance of the undergraduate student nurse clinical placement, is now commonly known as work-integrated learning (WIL) (Billett, 2002). Billett’s (2002) explanation of WIL revolves around workplace pedagogy, indicating that there is a co-participation aspect for students who undertake a work integrated learning experience. Co-participation considers the various different actions that support what the student understands about the clinical work integrated placement. This is achieved in the workplace by participation in work activities through direct and indirect guidance (Billett, 2000, 2004). Billett (2008, p. 39) suggests that “learning continues throughout ones’ working life and has a relational interdependence between personal and social means” (p. 39). This relatedness is recognised in nursing, where clinical facilitators help to socialise the students into the workplace using direct and indirect supervision while integrating the theoretical components of their course in the practical areas. Direct supervision as defined by Australian Health Practitioner Regulation Agency (AHPRA) occurs when “a supervisor is physically present at the workplace, and available to observe the supervisee when they are providing care” (AHPRA, 2013, p. 9). In comparison indirect
supervision is “when the supervisor is easily contactable and available to observe and discuss the nursing /midwifery care the supervisee is delivering” (AHPRA, 2013, p. 10). Within the role as a clinical facilitator both direct and indirect supervision occurs in the practical setting.

Clinical facilitators and their role are viewed variably by health care agencies, students and universities often depending on the clinical context; although most agree that the role is extremely important (Courtney-Pratt, Fitzgerald, Ford, Marsden, & Marlow, 2012). From the employers’ perspective, clinical facilitators supervise and work with student nurses, assessing and nurturing them through their clinical placements, while monitoring and evaluating their development to ensure that the theoretical knowledge is linked to practice. Student nurses consider that the clinical facilitator is there to work with them and assess their performance while undertaking the clinical placement (Lee et al., 2002). Universities in Australia have position descriptions and some have extra duty statements for clinical facilitators, but under different titles to describe the expectations of the clinical facilitators’ role. Clinical facilitators must understand the expectations of the university learning about the outcomes and curricula, to engage the students in effective learning. Their role also entails supervision, the main functions of which are “identified from the perspective of the education provider (the university) and the health service” (HWA 2010 p, 11). HWA’s (2010) report does not describe the perspectives of the facilitators themselves as to what they believe are the main functions of their role. Feedback from clinical facilitators employed at the researcher’s university has indicated that their role is to support the socialisation of the student, which concurs with Forsyth’s (2009) view. Acknowledging the importance of socialising students, researchers describe a good facilitator as someone who identifies and supports learning opportunities while having patience and empathy (rather than sympathy) for the student (Cross, Moore, & Ockerby, 2010; Winstanley & White, 2003).
Models of clinical facilitation

As well as the variability in terminology and educational preparation, there are different facilitation and supervision models in Australia. Clinical facilitators have traditionally been employed by the university (Dickson, Walker, & Bourgeois, 2006). However, during the past four to five years, particularly in Queensland, health care agencies recruited and employed the clinical facilitator from their own nursing staff pool. This employment model continues to occur in some health care agencies, although more recently with the changes in government there has been a shift back to employment of clinical facilitators by educational providers. In Australia, the model of clinical facilitation is usually at a ratio of one facilitator to six or eight students (1:6 or 1:8) (Dickson et al., 2006; Health Workforce Australia, 2010; Sanderson & Lea, 2012). Ratios have historically been determined by the regulatory authority and health care agencies to provide the students with sufficient support in the clinical settings to ensure that patient care is not compromised.

Since the 1990’s, Queensland universities have conformed largely to the 1:8 ratio (Conrick, Lucas, & Anderson, 2001), whereas some other states vary, with Tasmanian facilitators overseeing up to 12 undergraduates per shift Courtney-Pratt et al. (2012). Courtney-Pratt et al. (2012) also suggest that in Tasmania, like Queensland, undergraduate students could be scattered across the health care agency in different ward areas. Healthcare agencies may alter the ratio and distribution of students to clinical facilitator according to the ward areas to be used, dependent on the requirements of both the health care agency and the university. Irrespective of ratios, university expectations of clinical facilitators is guided by the curriculum, retention of students and effectiveness of the clinical placements. The clinical facilitator has considerable responsibility for effectively orientating and socialising the group of undergraduate nurses to the health care agency and ward area in which they are placed as well as teaching clinical skills and monitoring their progress.
Educational preparation for the role of facilitator

It is unclear from the literature how the clinical facilitators are educated for the role and what they understand of their role. Educational preparation of clinical facilitators varies both in Australia and internationally. Within Queensland some clinical facilitators have undertaken a graduate diploma or master’s degree in their specialist field; for example, emergency nursing or critical care. Many clinical facilitators do not have any formal teaching qualification at an advanced level, such as a Graduate Certificate in Higher Education or Diploma of Teaching (Conrick et al., 2001; Minter, 2011). Within the Department of Health Queensland Health (public sector) and some private sector health care organisations there are preceptor programs conducted by the employing organisations, and some staff have been encouraged to undertake a Certificate IV qualification in Training and Assessment if they are going to be working with new graduates or students. There is also variability in the selection criteria within position of clinical facilitator across Australian universities. While some universities do not require an educational degree to undertake the role of clinical facilitator, others ask that the clinical facilitator hold or is working towards an appropriate tertiary qualification in education. The variability in education and in some instances, the lack of educational qualifications suggests the need to investigate facilitators’ understanding of the education, support and performance needs for the role.

In the context of my role as a Professional Practice Coordinator at a South East Queensland university, informal conversations with colleagues and feedback from existing clinical facilitators indicated that many clinical facilitators in the early 1990s assumed the role of clinical facilitator without formal qualifications to underpin what they were doing. According to Napthine (1996) educational standards were similar across Australia at that time and little has changed. Many of these clinical facilitators continue to be employed today as clinical facilitators with various Queensland universities. Few formal processes of monitoring performance have existed to ensure safe, high quality facilitation practices, and often student feedback has been the only means of performance review. Many clinical facilitators who make the
transition to the educational system are clinicians with varied experience and specialisations. The extension of the clinical role to an educational role leads to questions about the ability of registered nurses to undertake clinical teaching and assessments, particularly in their ability to link theory to practice for the undergraduate student nurses. One aspect of this question relates to the challenges of clinical facilitation.

The challenges of facilitation

Clinical facilitators have an important role in facilitating education which is undertaken specifically by helping with the learning of skills in the clinical environment. Researchers have found that the most optimal approach to skills development is through scaffolding. The term scaffolding was first introduced by Wood, Brunner, and Ross (1976) who described it as a “process that enabled a child or novice to solve a problem, carry out a task or achieve a goal which would be beyond their unassisted efforts” (p.90). Scaffolding supports learners to construct new knowledge, building on the person’s existing knowledge (Hydo, Marcyjanik, Zorn, & Hooper, 2007; Jordan, Carlile, & Stack, 2008; Sanders & Welk, 2005). This statement infers that without the assistance of someone else providing the support system to guide the learning, the knowledge or tasks may be unachievable. The process of scaffolding was further elaborated by Vygotsky (1978) whose theoretical model explored the psychological processes involved in learning, and through strategies such as modelling, feedback, questioning, instructing and cognitive structuring all of which support the student to learn. Many clinical facilitators without formal educational preparation may be unaware of processes such as scaffolding, and other strategies to optimise student learning.

Undergraduate student nurses are novices in their clinical practice, and the clinical facilitator assists them by implementing on the university curriculum. The students are expected to use previous knowledge and experiences from their laboratory sessions and other life experiences to scaffold their learning. They build their knowledge and practical nursing skills
while linking the theoretical components with practice. The clinical facilitator supports the students by consolidating classroom and laboratory learning to help students develop and extend this integration of knowledge. In the clinical setting this involves assisting the student to achieve skill and task independence through keeping them on task, providing repetition and guiding the students through to completion of tasks. Breaking the tasks into manageable chunks where the problem at hand is unpacked helps the student understand the application of theory to practice, while removing ambiguity around the tasks at hand (Sanders & Welk, 2005). This learning approach is incremental and should be paced individually. By scaffolding the learning the clinical facilitator can also assist the student to fulfil their clinical goals while on clinical placement, which can encourage students to persist with their studies, thereby promoting retention. Clearly, scaffolding learning is an important concept for all involved in student education, yet Jordan et al. (2008) reports that educators are usually not adequately trained in strategies of scaffolding. This lack of exposure to educational theories and approaches may also be the case for clinical facilitators, who may not be exposed to the range of pedagogical concepts used in theoretical components of the students’ program.

Being the support person for students may also present challenges. Although many clinical facilitators are able to identify poor performing students, feedback from facilitators has identified that at times, they find it difficult to place students who are under-performing onto a formative review (also known colloquially in Australia as learning contracts) without the assistance of the course convenor or professional practice coordinator. According to Fry, Ketteridge, and Marshall (2003) a formative review is a formative assessment that sets out specific learning goals and outcomes between the facilitator and the student. The goals and outcomes are negotiated and need to be demonstrated by the learner with the support of the clinical facilitator, for example; the learner to arrive on time to placement. A summative assessment of the students’ clinical skills is also completed by the clinical facilitator and occurs at the conclusion of the placement. As the liaison person between the education provider and the health care agency,
clinical facilitators have a responsibility to ensure that the clinical placement runs smoothly with good channels of communication to convey any issues of concern with students to the education provider (Griffith University, 2011). Feedback also indicates that some students have challenged clinical facilitators using intimidation, particularly if the RN is new to the role of facilitation, and this can occur if the student has a strong personality. Other challenges that the clinical facilitator may encounter include assessing students from non-English speaking backgrounds, especially where they are not experienced with this type of student. Students with undisclosed or unmanaged medical conditions also pose challenges as the clinical facilitator needs to be aware of how to manage illness in accordance with university policies governing. Many of these challenges can be met through an understanding of theoretical and practical knowledge of learning and teaching and the expectations that the university has for the role.

The research problem

There are limited documented or published studies on clinical facilitators’ perceptions of clinical facilitation of undergraduate student nurses and what constitutes best practice in the role. Interconnected with the lack of research is the lack of understanding of educational preparation required for the role and their motivations to undertake this as are the reasons that attract registered nurses to the role. The lack of empirical evidence means that it is difficult to readily identify the dimensions of the role, provide adequate, targeted supports for clinical facilitation, or develop educational components appropriate for the role. The formal expectations of employers of the role of clinical facilitators are limited to job descriptions or job statements, although these are variable across different universities. There is limited published research or evidence that examines the extent to which education providers and health care agencies’ expectation of clinical facilitators varies and the extent to which any differences have an influence on the practice of facilitation. While the support mechanisms afforded for students have been discussed and debated over many decades (Price, Hastie, Duffy, Ness, &
McCallum, 2011) there is little evidence what clinical facilitators perceive as best practice in the role of clinical facilitation. Understanding best practice would allow educators to teach to best practice rather than historical assumptions of the requirements for the role.

What is known is that the ideal facilitator must be an independent, practising health-care professional who has the capacity to apply, monitor and understand theoretical concepts and link these to the undergraduate student nurses’ practice. While fulfilling the demanding role of clinical facilitation the clinical facilitator must understand undergraduate nursing curricula, expectations of the university and relevant theoretical components of learning and teaching.

Purpose of the study

The purpose of this study was to explore and interpret clinical facilitators’ perceptions of best practice in the clinical facilitation of undergraduate nursing students and the clinical facilitators’ views on what influences best practice to inform education for the role. The study examines perceptions of clinical facilitators in light of the complexities of their experience in their role, including educational qualifications, interaction with students and staff in health care agencies, barriers to clinical facilitation and influences on their learning and teaching.

Research question

What are facilitators’ perceptions of best practice in clinical facilitation of undergraduate nursing students?

This question informed four subordinate questions, namely:

1. What are the barriers and enablers to providing best practice?
2. What are the influences that attracted them to the role of clinical facilitator?
3. What are their expectations of the educational preparation necessary to undertake the role of clinical facilitator?

4. What are the personal and professional characteristics required from the clinical facilitator to provide best practice?

Assumptions

I embarked on this study holding a number of assumptions, including the contention that clinical facilitators are crucial to student success in the BN. As the literature review shows in the next chapter, little is known about clinical facilitators. There is little known about whether clinical facilitators undertake the role with unclear or imprecise understanding of what the role entails. As established in this chapter and further developed in Chapter 2, clinical facilitators may not have had adequate grounding in educational principles and practice. Further, there are a range of personal and professional elements and experiences in the facilitators’ approach to the role of clinical facilitation. Finally, the study is based on an assumption that through experience, clinical facilitators have insights into what constitutes best practice.

Significance of the research

This study interprets what constitutes best practice clinical facilitation of undergraduate Bachelor of Nursing students. It is important to understand and articulate how the clinical facilitator provides best practice to contribute to the successful completion of clinical placements. The study is significant in providing information that will be useful to educators in identifying the strengths and constraining factors that impact on this important aspect of nursing education. Because the study has identified influences on best practice the findings will inform measures to support quality and best practice of clinical facilitation, including educational preparation and clinical support for clinical facilitators. This information will ultimately advance knowledge of pedagogical processes for improving nursing education.
Organisation of the thesis

This thesis is organized into five chapters. This chapter introduces the background and focus of the study and outlines the research questions. Chapter 2 presents a critical review of the literature relevant to this study, providing a critique of literature on education for Bachelor of Nursing students and clinical facilitation as a component of that education. The conceptual framework is also outlined in Chapter 2. The research design and methods used to interpret and understand the perspectives of clinical facilitators are described in Chapter 3. The selection of case study as the research method is explained and justified in the first section of the chapter. Chapter 4 presents the findings of the study; that is, the perspectives of the clinical facilitators about their role, the structures and what constitute clinical facilitation. Chapter 5 provides a discussion and the implications of the findings in relation to teaching, practice and further research.
CHAPTER 2: REVIEW OF LITERATURE

Introduction

This chapter presents a critique of the current literature relevant to this study within three areas of interest. First, the chapter situates the study in a body of literature relating to the role of the clinical facilitator of undergraduate nursing students internationally and in Australia. Second, studies are critiqued in relation to educational preparation for the teaching role of the clinical facilitator. Third, studies relevant to the integration of theory and practice are examined. The chapter concludes with a summary of literature indicating where there are gaps in knowledge and that could be addressed by developing the basis for best practice guidelines.

Search strategy

A computerised search of databases including ScienceDirect, CINAHL, Medline (via Ovid), Proquest, Eric and Vocational education and training database (Voced) was conducted. In addition, websites of professional bodies related to nursing were searched to locate relevant documents. Keywords used to undertake the literature review included: clinical facilitator, clinical teacher, fieldwork supervisor, clinical facilitation, and clinical supervision, undergraduate student nurse, nursing history, educational theories and adult education/learning. The search has considered both Australian studies and international research from as early as the 1980’s for the study. Although a focus on clinical facilitation was not evident in the Australian literature until the 1990s, some Australian studies of models of supervision, group facilitation and staffing of undergraduate clinical learning programs were accessed. These aspects of clinical facilitation have continued to evolve in the nursing research agenda due to the increasing demand for clinical placements and expectations that undergraduate nurses will be clinically ready to undertake their clinical experience (Dickson et al., 2006).
Research into the role of the clinical facilitator

As outlined in Chapter 1, there is considerable published literature on the topic of clinical supervision and clinical placements, particularly descriptive reports of the role. Articles were reviewed and those relevant to the study have been presented, including a combination of peer reviewed and non-peer reviewed articles being reports or descriptions outlining clinical supervision, clinical teaching or clinical facilitation and the clinical facilitator in various contexts. Few articles provided clarity on research methods and how the research was conducted. Scanlan’s (2001) research considered how the facilitator learns to be a clinical teacher, and another scholarly report by Dahlke, Baumbusch, Affleck, and Kwon (2012) discusses the clinical facilitator’s role in nursing education. A small number of studies reported on students’ perceptions of effective clinical teachers, and these are critiqued in the sections to follow (Benor & Leviyof, 1997; Kelly, 2007; Knox & Mogan, 1985; Lee et al., 2002) and (Mogan & Knox, 1987). International studies from Canada and the USA, the United Kingdom and Israel will first be examined followed by a critique of Australian studies. This sequencing of the review is intended to provide themes that show similarities and differences internationally of how the clinical facilitators have professionally and educationally developed their role, identifying the gaps in knowledge that could be addressed.

North American Research studies

The research in Canada provided information about student perceptions of clinical teaching and novice facilitator interactions with students, while other North American studies considered baccalaureate graduate perceptions regarding their clinical experiences and clinical teacher behaviours. Research conducted by Knox and Mogan (1985) compared the importance of five categories of clinical teacher behaviours (teaching ability, nursing competence, personality traits, interpersonal relationship and evaluation). Their description of the role indicates that the North American clinical teacher is similar to that of the clinical facilitator in Australia in that the
clinical teacher like the clinical facilitator works with and guides the students. Knox and Mogan (1985) considered the thoughts and perceptions of university staff, students and practising graduates. The study was exploratory and undertaken at a university School of Nursing in Western Canada. A number of questionnaires were distributed in total 666 including 500 students, 66 faculty members involved with teaching and a random sample of 100 graduates from the four-year baccalaureate degree. The nursing faculty supervised and guided student practical experiences. The study had two research questions. The researchers asked whether there was a significant difference between the rated importance of the five categories of effective clinical teacher behaviours (evaluation, interpersonal relationship, nursing competence, personality and teaching ability) as perceived by university faculty, undergraduate nursing students and practising baccalaureate graduates. The second question asked if there was a significant difference between importance ratings made by university nursing faculty, undergraduate nursing students in the different years of a baccalaureate nursing program, and practising baccalaureate graduates in the five categories of effective clinical teacher behaviours (Knox & Mogan, 1985, p. 27).

Knox and Mogan (1985) measured responses using a 47-item survey, the Nursing Clinical Teacher Effectiveness Inventory (NCTEI), developed by the investigators from a previous study in 1983 (Mogan & Knox, 1983). The NCTEI is a checklist that describes teacher behaviours and characteristics clustered into five categories from student perceptions of effective clinical teaching. While the results of Knox and Mogan (1985) study highlighted no significant difference between the perceptions of the three groups in relation to effective clinical teacher behaviours there was a difference when the student cohort was split into the four year levels in the perceived importance of the clinical teachers’ behaviours. In particular, the first year students considered interpersonal relationships and personality of the clinical teacher very important; whereas second year students in the study considered both these attributes quite low, with personality being the lowest attribute across all categories. The third year students apportioned evaluation and
interpersonal relationships the highest attribute across all six groups of participants. The findings from this study offered interesting insights into the perceptions of the groups in question, but, as a cross-sectional study limited to one university Knox and Mogan highlighted that the findings cannot be generalised. Knox and Mogan (1985) recommended further exploratory studies to contribute to the scant research data in the area of clinical teaching.

The same researchers followed up with a study two years later (Mogan and Knox, 1987) using the NCTEI, slightly modified from the previous study. The research questions were different in that the 1987 study questioned the specific characteristics differentiating ‘best’ and ‘worst’ clinical teachers. This was rated by both the students and faculty. The second question measured the difference between the five identified characteristics in the 1985 study; that is, the differences between categories for ‘best’ and ‘worst’ clinical teachers. The 1987 study included 201 participants from seven university schools of nursing across western Canada and the United States. The participants included 28 clinical teachers and 173 undergraduate student nurses across the various year levels, excluding first year. Comparisons were conducted of the 10 highest rated characteristics by both students and faculty for both the best and worst clinical teachers. Findings showed that faculty and students had similar perceptions of best clinical teachers, while there were some differences in the perceptions of worst clinical teachers. Mogan and Knox (1987) concluded that “the teaching/learning process is a complex human transaction, dependent on a multitude of variables - psychological, sociological, and environmental - which have to be studied before definitive results can be forthcoming and recommendations for effective teaching can be advanced” (p. 337). Mogan and Knox (1987) recommended that further studies of clinical teacher behaviours be conducted, not only through surveys but include studies involving direct observation. While their work has contributed to the body of knowledge in relation to the perceptions of students and faculty of clinical teachers the evidence is more than 25 years old and doesn't include the perceptions of the clinical teacher (facilitators).
Two studies of students’ perceptions of effective clinical teaching were conducted over a 14 year period by Kelly (2007); one in 1989 (102 students) and a second in 2003 (161 students) at the Thompson Rivers University, formerly the University College of the Cariboo, Kamloops, British Columbia, Canada. The students interviewed were from both second and third year. While the curricula differed, the clinical placements remained similar, with the teacher-student ratio at 1:8 in acute and long care settings and 1:12-to-16 in community settings. In both studies students’ opinions were sought on the most effective clinical teacher who they had experienced, the three most important qualities of clinical teachers (ranked), and what influenced their clinical learning. While results from both studies were similar, particularly the expectation of teacher knowledge, different themes emerged from the second study. In the latter study clinical teachers’ feedback and communication skills received equal emphasis from students. In study one, communication skills were categorised as ‘empathy’, while students in study two discussed the teacher’s communication skills as the ability to listen and be calm (Kelly, 2007). Both studies in Kelly’s (2007) report suggested that teacher availability was a concern, although the third year students held less concern in this regard than the second year students. Finally, findings suggest that nurse teachers must be able to demonstrate advanced theoretical, clinical and pedagogical knowledge (Kelly, 2007). While the study by Kelly (2007) considered the effectiveness of the clinical teacher the research did not identify what constitutes the practice of clinical facilitation and the perspectives of the clinical teacher who undertakes the facilitation of students.

Di Prospero and Bhimji-Hewitt (2011) conducted a study in a Canadian university with six novice facilitators and their interactions with approximately 250 students from seven health professions excluding nursing and medicine (Nuclear /Medicine, Radiological Technology and Radiation Therapy), who were enrolled in a first year inter-professional collaboration course. The aim of Di Prospero and Bhimji-Hewitt’s (2011) research was to present faculty perspectives (faculty in this instance were teaching staff) of facilitated teaching. The facilitated teaching was in classrooms similar to
Australian tutorial sessions. The study included debriefing sessions where researchers collected qualitative feedback on facilitation. Although the research was not conducted in clinical settings, the participants reported that based on their experience in facilitative teaching, a challenge they faced was to manage tension and conflict. According to Di Prospero and Bhimji-Hewitt (2011) “the facilitators’ minimal skills in guiding discussion as well as interactive teaching caused apprehension when facilitating the groups (p63).” The facilitators recommended that a guide to facilitation that included expectations of the role and key learning outcomes would be beneficial. A limitation of the study is that in spite of the inclusion of seven health professions in the study there was a noticeable lack of participants from nursing and medicine, which the authors explained on the basis that the university where the research was conducted does not educate these two professions. While the Di Prospero and Bhimji-Hewitt (2011) study recommended initiatives for novice facilitators, the study was limited to the classroom rather than the clinical setting. Another perspective on the effectiveness of clinical teaching has come from feedback from new graduates.

Hickey (2010) conducted an exploratory study of baccalaureate nursing graduates to examine their perceptions regarding academic clinical experiences and whether they felt prepared to enter the practice area. The setting for the study was a generic nursing program at one of the largest, urban universities within the United States. Questionnaire surveys (108) were sent to graduates from the 2003 and 2004 cohorts, with 33 returned (31% response rate). Quantitative and qualitative analysis revealed students’ perspectives of the clinical teachers’ positive behaviours as facilitating learning and communication while seeking learning opportunities. Once again, the researcher has considered the perspective of a student cohort, albeit as graduate registered nurses. While the past students were insightful of their needs of clinical teachers, no data were collected on clinical facilitators’ perception of their role and practice. However, the focus on student perceptions on clinical facilitation practice has been a major aspect of
research in other countries, and underlines the importance of communication in practice.

*Other international research into the clinical facilitator role*

Ten years after the studies by Knox and Mogan (1985) in Canada, Benor and Leviyof (1997) investigated psychological issues such as student perceptions of effective teaching and what the student considered best and poor clinical teaching in nursing in Israel using a modified approach of the Canadian study. Three Israeli nursing schools participated in the study with 123 students in total responding to a modified version of the Knox and Mogan (1985) tool (NCTEI). The findings indicated that the Israeli students considered the teachers’ competencies as the most important, followed closely by student evaluation, which included evaluation criteria and feedback. Evaluation in this instance was the assessment by the clinical facilitator of the students’ ability, skills and knowledge. Instructional skills, which included teaching competencies and interpersonal relationships between the teacher and the students, was considered less important by the students in the Benor and Leviyof (1997) study. Like the students in Mogan and Knox’s (1983, 1987) studies, personality, which included the personal traits, attitudes and behaviour, was considered the least important. Benor and Leviyof (1997) study was limited to a small cohort of Israeli students from various year levels of the nursing program across three universities. They concluded that students have a mental picture of an ideal clinical teacher, although the study did not examine how students created this image. Findings by Benor and Leviyof (1997) indicated that students realised that even the best teacher does not live up to students’ expectations of the ideal clinical teacher. Moreover, the findings of the students’ perceptions hinted that while a clinical teacher is considered the best clinical teacher, students may not look to the person as a major role model. The study did not elaborate why, although Benor and Leviyof (1997) suggest that the study was small and recommended further larger studies to shed light onto the psychological issues of student perceptions.
The preceding studies demonstrate a number of themes; addressing how clinical facilitators learn their role, perspectives on what constitutes effective clinical supervision, students’ perceptions of the role and similarities and differences in supervision among North American and Australian clinical education systems. The North American research considered different aspects of student clinical placements including the student perceptions of the clinical teacher and what they considered effective teachers. Some of the research has used the same 47-item survey checklist to describe teacher aspects. The North American research also included graduate nurse perceptions of academic clinical experiences and how prepared they felt for the clinical placement. The studies by Knox and Mogan (1985) and Benor and Leviyof (1997) were conducted in Canada and Israel respectively where there may be some contextual differences to Australian facilitators and students. There have also been studies in the United Kingdom and Ireland that shifted the focus to education preparation for the role of clinical facilitator.

**Educational preparation for the role of clinical facilitator**

*United Kingdom and Irish Research*

While North American and Israeli research considered student and graduate perceptions of clinical placements, the United Kingdom and Irish literature focused on the role of the clinical facilitator and the development of a guide to effective educational and clinical supervision. A discussion paper by Beckett and Wall (1985) examined the role of the clinical facilitator in relation to student learning. Their analysis of the clinical facilitator role was based on the work of other authors, including the philosophy of Carl Rogers who, through his work on patient centred therapy, developed a student-centred approach to learning. Herron’s research (cited in Beckett and Wall, 1985) identified six dimensions to facilitating. These six dimensions relating to facilitating developed by Herron in 1977 are:

1. Directive-Non-directive: responsibility is the facilitators or delegated to the student.
2. Interpretive-non-interpretive: the facilitator explains the situation to the student or does not reveal anything to the student.

3. Confronting-non-confronting: facilitator confronts behaviour or assists the student to self-confront a situation.

4. Cathartic-non-cathartic: facilitator assists to create a therapeutic release versus a tension filled situation.

5. Structuring-non-structuring: the facilitator has structured or non-structured experimentation in the process of setting up learning for students.

6. Disclosing-non-disclosing: The facilitator shares their own feelings, or does not and remains closed to the student.

   (Beckett and Wall, 1985 p261)

Beckett and Wall (1985) suggested that the above dimensions of Herron’s approach allow the facilitator to develop their own style of facilitation dependent on the circumstances of the students who are being facilitated; that is, they are not mutually exclusive. Informal student feedback in Australia shows that many current education staff utilise student centred approaches to learning to assist with retention of students in tertiary institutions. Through this approach there is awareness that both the facilitator and the student have needs. Carl Rogers identified in 1983 that facilitator needs are to include: (i) an awareness of oneself, (ii) the ability to respond to the feelings of the learner while recognising one’s own feelings, (iii) acceptance of the trust of the student and (iv) the ability to empathise with the student (Beckett & Wall, 1985). According to Beckett and Wall, while the facilitator has needs they must also manage the learning of the students and direct the learner in the clinical environment. It must be noted that not all the learning can be self-directed and that the clinical facilitator should acknowledge that they are responsible for decisions about the learning environment. Beckett and Wall (1985) concluded that:

“Clinical facilitators are those that have a commitment to ongoing education; derive their strength from their own expertise, self-worth and autonomy, and are therefore capable of motivating the learner. The process of communication, mutual support and
acceptance, intrinsic in the idea of facilitation, will lead the student of nursing to self-directed learning pursuits, to seek support from a facilitator”.

While Beckett and Wall (1985) concluded that clinical facilitators had a commitment to ongoing education and had specific needs they also identified that the clinical facilitators were required to manage the students’ learning environment. Their study was conducted more than 25 years ago and since that time the ongoing education of clinical facilitators has not been the subject of sustained, systematic research. Nor has there been any cross-national comparison of education for clinical facilitators, despite the understanding that context is an important aspect of any learning strategy. For example, one of the differences between international and Australian hospital experiences is that students in most countries have four years to become familiar with their facilitators. In Australia, the Bachelor of Nursing is a three year program with shorter courses and placements and a narrower range of clinical placements, where for example paediatric placements are limited with a relatively small number of students attending a two week clinical placement in paediatrics. This difference in course duration is a major issue for Australian students. However, the Australian experience may be similar to clinical facilitation in the three year diploma course offered in other countries, as research in Ireland has shown.

In Ireland, researchers undertook an exploratory study of registered nurses facilitating supernumerary diploma student nurses in the clinical area using a phenomenological approach with semi-structured interviews (O’Callaghan & Slevin, 2003). The sample was purposive, with selection criteria including at least one-year experience working as a RN, which included first-hand experience of facilitating supernumerary diploma students. The RNs explained their experiences as trying to create an environment conducive to learning. They found the role of the clinical facilitator rewarding and felt their own learning and professional practice had been enhanced by the experience (O’Callaghan & Slevin, 2003). However,
they also revealed that despite positive experiences of facilitation the role
could be stressful to the point of frustration. At the time this study was
conducted the diploma program in Ireland was very new to the participants of
the study and the researchers suggest that there may have still been
resentment from change to the new model of education from the apprentice
model. While O’Callaghan and Slevin (2003) identified the need for further
research on a larger scale to identify difficulties, it was not clear whether they
refer to difficulties for the clinical facilitator in facilitating learning, or difficulties
for the students in trying to complete the clinical components of their
program. They do however; suggest that further research should be
conducted into how the student nurse viewed the experience of being a
supernumerary learner. In Australia, nurses have also been supernumerary
learners for many years.

Another area of research into students’ clinical learning involves the
development of educational guides for clinical supervision. Kilminster,
Cottrell, Grant, and Jolly (2007) developed a guide to effective educational
and clinical supervision that could be used for anyone who supervised others
in medical clinical practice settings. The AMEE Guide No. 27: Effective
educational and clinical supervision was based on work conducted in the
United Kingdom by the researchers in 2002 where they explored clinical
supervision of trainee doctors (Kilminster et al., 2007). The researchers
discussed common features of supervising trainee doctors and health care
professionals including psychotherapy, social work and nursing, which
corroborated other researchers’ findings that the focus of clinical supervision
is to maintain patient safety and quality patient care (Health Workforce
Australia, 2011). The clinical facilitators are expected to maintain the focus of
patient safety and quality patient care while ensuring that the students
integrate their theoretical knowledge to the clinical setting. A supervisory role
gives the impression that the person will manage the behaviour and
discipline of the person being supervised, while facilitation gives the
impression of nurturing the student and guiding them. Kilminster et al. (2007)
suggested that while clinical facilitation is a form of supervision, the practice
of supervision is variable, and that effective supervision of a trainee involves
giving feedback on the students’ ability and performance both clinically and theoretically. While there is a substantial volume of literature relating to supervision it is difficult to clearly ascertain what clinical facilitators in the UK understand about their own practice.

Australian research

An analysis of Australian literature reveals three key themes in relation to clinical facilitation. Themes include studies on the characteristics of clinical facilitators and variability in their role, effectiveness in the role, as well as publications that address the theory-practice gap. The theory practice gap as noted in chapter one was a term coined by Marlene Kramer in 1974 to refer to the misunderstanding between those who taught theory and the clinical practitioners. Australian researchers have highlighted the effectiveness of the role. Consideration of effectiveness in clinical educators was one of the issues that Kelly (2007) addressed in her North American study. The Australian literature includes research examining clinical facilitators’ perceptions of effectiveness in clinical facilitation. There is a parallel between what Australian researchers were interested in and what the United Kingdom and North American researchers were interested in, including examining the role and its variability and the effectiveness of the clinical facilitators. Australian researchers Lee, Cholowski and Williams (2002) investigated nursing students’ and clinical educators’ (clinical facilitators) perceptions of effective clinical educators in one university school of nursing in New South Wales. The study replicated the study by Mogan and Knox (1987) using the Nursing Clinical Teacher Effectiveness Inventory (NCTEI). Survey questionnaires were received from 104 second-year students (69.3%), 30 third-year students (26.8%) and 17 clinical educators, representing a 50% response rate from a sample of 296. Because of the low response rate from the third year cohort the analysis was only included the second year students. Some of the findings by Lee et al. (2002) are similar to those of Mogan and Knox (1987). For example, students identified the top rated characteristic of the clinical teacher as ‘being a good role model’. Although, this study did not explore what a clinical teacher actually did for them as
Mogan and Knox (1987) had done in their earlier study. The study by Lee et al. (2002) found that nurse educators and teachers were not defined, with the terms used interchangeably. In addition, the nurse educators in the study were predominantly inexperienced with 12 having less than 12 months experience in the role. In terms of education, 14 of the 17 had nursing qualifications from a university school of nursing, six had postgraduate qualifications and one had a Master of Nursing. This paper notes that the data on facilitators’ qualifications was incomplete and there was no reporting on educational practices of the clinical facilitators. While Lee et al. (2002) suggest that greater emphasis should be given to teaching ability, there is little attention in the study on the clinical educators, their educational qualifications and their understanding of education practices. Australian researchers have also studied facilitators’ perspectives on their own individual experiences of supervision (Dahlke et al., 2012).

A phenomenological study to discover the lived experience of four clinical educators from different Victorian universities providing pre-registration bachelor of nursing students attached to their experiences as clinical educators was conducted by Ferguson (1996). The study revealed five themes of their lived experience, including: a) being human; b) having standards; c) developing own teaching style; d) learn as you go; and e) not belonging (Ferguson, 1996). The findings revealed that the clinical educators had feelings of isolation and were often confronted by complex student issues or agency problems, which they found difficult to resolve. While the results of the study identified that the clinical educators required extensive preparation for their role and on-going support, there was no evidence within the research to highlight what they considered best practice for the role of clinical facilitation. The study did highlight, however, that the clinical educators felt they learnt as they went along and needed to develop their own learning style. Ferguson (1996) concluded that strategies needed to be addressed to support the clinical educators and maximise their effectiveness, particularly in the situation where resources allocated to nursing were severely stretched. While this study was undertaken more than 15 years ago, the resource issue remains pertinent, particularly in today’s circumstances.
where universities have had to limit clinical facilitation due to the exorbitant and increasing costs of clinical placements (Mather, 2011).

Sanderson and Lea (2012) also undertook a phenomenological study of clinical facilitators’ experiences and understanding of their role, including their perceptions of the barriers to clinical learning for undergraduate nursing students within a rural Australian setting. Eight clinical facilitators purposively sampled from the university’s clinical facilitator database were interviewed on the basis that they had experienced the clinical facilitation model of clinical education within the rural context. The study identified three themes from the narratives: i) structuring the rural clinical placement; ii) structuring student learning in the rural health service; and iii) barriers to clinical education in the rural environment. According to the authors they only had scope to report on the first two themes, because of the limitations of the publication. The researchers indicated that the clinical facilitator’s role included assisting students to improve their time management skills, prioritisation skills and bridging theoretical knowledge with the practice component, along with conducting orientation and support through debriefing sessions. This study by Sanderson and Lea illustrates the importance of ensuring congruence between theory and practice, and the importance of clinical facilitators being provided with the opportunity for students to develop professionally and personally. These researchers, like Lambert and Glacken (2005) and Dickson et al. (2006), recommended that further study into the nurses’ perception of the facilitator role and the relationship facilitators have with clinicians be explored. While Sanderson and Lea’s (2012) study identified that the role of the clinical facilitator in the rural setting was essential for the student to have the opportunity to undertake clinical placements, like other studies, these researchers did not draw any conclusions from their findings in terms of what constitutes best practice, perhaps because of the limited breadth of the study.

Some researchers have attempted to draw together the findings of previous research to provide insights into how the role is enacted in their particular context. A literature review of clinical supervision studies of registered nurses, some nursing students and allied health from 2001-2007...
was conducted by Butterworth, Bell, Jackson, and Pajnkihar (2008). This extensive review summarised insights from others and identified that supervisors required adequate training to undertake a supervisory role. The literature review reported the usefulness of clinical supervision as an educational and supportive device for the registered nurse. According to Butterworth et al. (2008) there are levels of engagement required in clinical supervision, although there was no conclusion about a standard time to spend with the supervisee. The researchers of clinical supervision highlighted improved effects on patient outcomes from staff receiving supervision from a more experienced person, as well as improvement in the disposition of staff, in some cases (Butterworth et al., 2008). The paper concluded that most literature reported clinical supervision as a positive experience and that student nurses who were supported and allowed time to reflect and develop made significant contributions to patient safety and well-being (Butterworth et al., 2008). Clearly, there is wide variability in the quality of facilitation across different contexts.

In response to student feedback indicating diversity in the quality of clinical education, Wellard, Rolls, and Ferguson (1995) undertook an evaluation of clinical educators at a Victorian School of Nursing at an Australian university. Three academic staff evaluated 39 clinical educators, who, despite varied backgrounds, had a minimum of four years of experience in the acute care environment. Their study found that while there was a position description available to the clinical educators, the position description required review. Anecdotal feedback given by cohorts of students prior to the study identified major concerns, which led to the study. These concerns included variability in the quality of clinical skills of the educators, variability in expectations of student performance across groups, and the overuse of written work in some clinical learning settings (Wellard et al., 1995, p. 738). Importantly, this study identified not only variability in the ability and skill of the clinical educators, but also in their expectations of student performance. Wellard et al. (1995) identified that one area of need was that the clinical educators required skill development in goal setting, in that they had difficulty developing concise language to develop goals and objectives.
with the students. The clinical educators were also unaware that they should challenge students’ knowledge while they undertook clinical placement (Wellard et al., 1995). From the evidence, it appeared that the clinical educators in the study were unaware of what the role of a clinical educator entailed, and the extent to which their understanding of educational practices would provide the undergraduate student with a quality learning environment.

Wellard et al. (2000) conducted a further study considering the staffing of undergraduate learning programs in 30 Australian preregistration nursing programs. The study reported current practices surrounding clinical learning programs in Australian universities, in particular staffing profiles used to support undergraduate clinical learning (Wellard et al., 2000). A national survey of preregistration undergraduate Bachelor of Nursing courses was undertaken, with selected case studies used to develop an understanding of the contextual issues of delivering clinical programs. Findings of the study revealed the range of supervision models across the universities and health care agencies. The findings also included concerns about the temporary nature of sessional work, a lack of acknowledgement and recognition of the role of sessional staff and the difficulties experienced in some geographic locations in retaining clinical facilitators. These researchers drew attention to the difficulty in recruiting suitable people into the clinical supervisory (facilitator) role, a problem that persists today. Preparation of the clinical facilitators varied enormously and the evidence from Wellard et al. (2000) indicates that it is important to address the education of clinical facilitators, which will be addressed in the next section.

O'Brien, Buxton, and Gillies (2008) investigated attempts to improve undergraduate clinical placement experiences in mental health using clinically-based facilitators within West Sydney Area Health Service. A pilot study evaluated a facilitation program that ran for six weeks including orientation to the unit and hospital along with patient activity programs and daily briefing sessions for the students with a clinical facilitator. The allocation of students was one facilitator to five students per shift. A pre-placement, post-placement and placement evaluation was conducted during the pilot. Questions included mentoring attributes, explanation of student and facilitator
responsibilities, access to facilitator and the students’ interest in mental health nursing. The questionnaires were completed by students with a response rate of 99% pre-placement, 96% post-placement and 81% placement evaluation. The results displayed little differences in the areas of importance pre and post placement in relation to mentoring attributes, although there were significant differences in the students’ expectations and experiences in relation to the facilitators, particularly in access to the clinical facilitator and the explanations of the facilitators’ responsibilities. Focus groups were used in the research and these included RN’s working with the students, facilitators and students. There was a specific focus group for facilitators with six participants, two focus groups of students and three focus groups of RNs who were buddied with the students. The students found the placement and program to be beneficial although they did not know what to expect from the placement. While some students identified that the university had provided them with tutorials prior to the mental health placement not all students had attended. Interactions between the registered nurses, students and clinical facilitators were considered, with the students indicating the importance of mentoring attributes, such as: “interpersonal skills, trustworthiness, sensitivity, patience, commitment to student learning, commitment to facilitation relationship, professional knowledge and skill to name some” (O’Brien et al., 2008, p. 512).

The registered nurses and clinical facilitators in the study by O’Brien et al. (2008) considered issues that were important to both the student and registered nurses. These included making the students feel welcome, the role of the RN in relation to student education and the uniqueness of mental health practice for undergraduate student nurses. The clinical facilitators highlighted different issues in their focus group which included raising the awareness for them of their own knowledge base in relation to the environment in which they worked, and the fact that they vested a lot of themselves into making the placement work for the student, and the need to alleviate fears. The facilitators in this study enjoyed the experience and found being in their own environment easy to facilitate, explaining that they hoped the students had a better understanding of mental health. While O’Brien et al.
(2008) included the clinical facilitators in the study they did not identify the length of time these people had worked as clinical facilitators, although they had had at least four years’ experience in the clinical area of mental health. The researchers were particularly interested in the learning experiences of the undergraduate students in mental health placements and improving these placements to increase the numbers of students who would apply for employment in mental health.

A different perspective was taken in a study conducted by Nash, Sacre, Lock, and Ross (2011). They evaluated the Leadership and Clinical Education (LaCE) program conducted at the Princess Alexandra Hospital in Queensland in collaboration with the University of Queensland. This program was designed to educate nurse leaders and develop resources for clinical supervisors to improve the learning of undergraduate nursing students. This program was designed specifically to enhance leadership of the clinical facilitators but did not consider the perceptions of the clinical facilitators. The program was found to be beneficial in developing the clinical supervisors. To date this program is the only one of its kind in Australia in nursing.

The broad issue of how clinical facilitators are educated and prepared for their role features prominently in the literature. Clinical facilitators have voiced concerns that they received little educational direction as to their role and what was expected of them when being employed to work with undergraduate nursing students (Napthine, 1996). Ferguson (1996) and Lee et al. (2002) identified that unqualified and unprepared individuals are often appointed into clinical educator roles. To some extent, this is related to budget constraints and managers having to employ sessional, rather than full-time clinical staff (Lee et al., 2002; Napthine, 1996). From the clinical facilitators’ perspectives, universities overlook their learning needs when they are only sessional employees. According to Napthine (1996) when some universities prepare the clinical facilitator for the role there may not be any consideration of educational or adult learning principles attached to the expectations. Napthine’s comments were made more than a decade ago, and it is unclear whether there has been a change or improvement in the educational preparation for facilitation.
Scanlan (2001) suggests that “clinical teaching in nursing is a complex phenomenon that lacks a coherent theoretical base and is perplexing to novices, who tend to teach as they were taught” (p. 240). Many registered nurses were taught through an apprentice model until the late 1980s and still practice and teach students and graduates in a similar manner. An old adage of ‘see one, do one, and teach one’ was considered the norm in teaching student nurses within the hospital schools of nursing under the apprenticeship model (Mason & Strike, 2003). The approach originated from the medical profession when they conducted medical procedures (Mason & Strike, 2003). This meant the student watched a procedure or learnt something new, then undertook the procedure themselves under supervision and they were then considered fit to teach the procedure to the next person. This type of approach was predominantly skill based and failed to integrate theoretical and practical learning. Preparation for facilitation is a continuing and important issue in the Australian and international context to ensure this integration of theory and practice is managed educationally.

Scanlan (2001) conducted an exploratory, descriptive study at the university of Manitoba, Canada and highlighted how clinical teaching is learned, which respondents predominantly suggested was ‘on the job’. Scanlan (2001) purposively selected five novice and five expert clinical facilitators for the study, identifying criteria to select the novices and experts to respond to five interview questions on clinical teaching. She explored the clinical teachers’ (who are similar to the facilitators in the current study) perceptions, thoughts and values; by asking them about their experiences as both a learner and teacher that have influenced the way in which they have taught. Topics included how clinical teaching had changed from when they first commenced in the role, what factors influenced those changes over time, their role as a nurse compared with that of a clinical teacher, and what changes they had made in their teaching. The selection criteria included two years or less clinical teaching experience for the novice clinical teacher and at least five years of experience for the expert clinical teacher. Directors and deans of schools of nursing where the research was conducted were asked to nominate suitable clinical teachers. A novice was defined only by the
length of time in the role. The expert was defined by being recognised by others as an expert, consistently rated highly by both students and faculty as successfully facilitating the development of students’ clinical practice, having tried innovative teaching strategies and whether or not, if they had a son or daughter in a nursing education program, they would want them assigned to the clinical facilitator. The participants were asked to keep a journal for two weeks during the interview process to identify their perceptions, thoughts values and beliefs of clinical facilitating, and there was the opportunity to include concept mapping in the study. Concept maps are a pictorial form used to link ideas together organising knowledge to provide meaningful learning (Gul & Boman, 2006). The clinical teachers were asked to draw concept maps to reflect their perceptions of clinical facilitation, and following coding the researcher also completed concept maps for each participant to assist with clarifying the researcher’s thinking. The concept maps were validated during a third interview with participants to ensure the participants had an understanding of clinical teaching. Findings of the Scanlan (2001) study identified processes through which clinical teaching is learned, which included experiences as a student themselves, their own experiences as a nurse, experience as a clinical teacher and experience with others, including other clinical teachers.

The novice teachers in Scanlan’s (2001) study suggested they floundered through trial and error when distinguishing what worked for them and what did not in various situations. Another aspect that assisted with their learning was receiving feedback about their clinical teaching ability, and the clinical facilitators suggested that feedback from students was the most common source. Staff identified as experts in the study suggested that their teaching expertise was developed when instructing patients during their care. Scanlan (2001) concluded that strategies to assist novice clinical facilitators are needed beyond just learning by trial and error. While the study by Scanlan (2001) is more than ten years old the findings are relevant because the role of the clinical facilitator remains essential to nursing education and future generations of nurses, because they assist linking the knowledge from the university and socialising the students into the clinical areas. Personal
communication with Scanlan on February 8, 2013 indicates that she has not followed up the 2001 study with further research and is unaware of others investigating this issue (Scanlan, 2013).

There have been subsequent studies examining the preparation for the clinical facilitator role. Dahlke et al. (2012) conducted a structured literature review of the clinical instructor role in nursing education, which is another term used for facilitator. The review summarised 15 papers published in English between 2000 and 2011. The paper identified the clinical instructors’ perceptions of their role, what they felt helped them in the role as teacher, and what also constrained their teaching in the clinical setting. The analysis by Dahlke et al. (2012, p. 692) identified four themes; characteristics of the role, characteristics of effective clinical teaching, influence of the clinical context on the role, and influence of the academic context on the role. Working under an assumption and expectation from academic (on campus) staff and students similar in that clinical instructors are both good clinicians and educators, Dahlke et al. (2012) suggests that clinical instructors also believe that these traits are expected. Dahlke et al. (2012) determined that clinical instructors often based their teaching on personal and clinical experience and that there is a lack of formal education and professional development opportunities for these staff. They concluded that universities should assess clinical facilitators’ knowledge of teaching skills and their learning requirements before they undertake the role. Currently the literature indicates that clinical facilitators base their work with students on their own experience as students, learn on the job and do not have formal education.

In addition to the literature considering students’ perceptions of clinical teachers and clinical facilitators, there are some texts containing guidelines that assist the student undertaking clinical nursing placement or a clinical fieldwork placement for health professionals (Levett-Jones & Bourgeois, 2007, 2011; Stagnitti, Schoo, & Welch, 2013, 2010). While the primary audience of these resources is undergraduate nursing students and students of other health disciplines, these books may be used as resources for the clinical facilitator. Although the books do not guide the clinical facilitators’
practice or educate the clinical facilitator in the role that they are undertaking in clinical education.

The literature so far highlights that facilitators lack knowledge in learning and teaching in clinical practice which will be further explored in the following section. The Health Education and Training Institute (2013, p. 12) (HETI) of New South Wales has developed a guide called The Superguide: A Supervision Continuum for Nurses and Midwives, which has been developed with the aim of providing clear and accessible information for both nurses and midwives about different types of supervision. Within the guide, supervision underpins a variety of models including clinical facilitation, buddying, clinical teaching and preceptorship with various descriptions. While the guide is easy to read it is very supervision oriented in a one-to-one ratio. The facilitator role is identified as encouraging students to be proactive in identifying and maximising valuable learning opportunities across a range of areas, as well as working within the nursing or midwifery team (HETI, 2013 p. 32). The guide provides some tips for clinical facilitation but does not address best practice or the issue of integrating theory and practice.

**Integrating theory and practice**

This section of the literature review will briefly explore pedagogical issues: theoretical aspects of learning and teaching, focusing primarily on studies that respond to the theory and practice gap. For example some of the studies cited below address ways to link theory and practice in the educational preparation of clinical facilitators. Horsfall, Cleary, and Hunt (2011) propose that “pedagogy includes considerations about nature of knowledge; what is taught; how it is taught, what is learning; and, how students and teachers learn” (p. 930). Kantor (2010) cautions that all teachers must be discerning about the type and amount of information that is disseminated to students in learning environments. He suggests that the learner is susceptible to content overload when the teacher believes that they must impart as much up to date information as possible rather than the student engaging in their own learning. While it has been traditional for the
teacher to impart knowledge, contemporary pedagogies have emerged that see learners becoming active participants in their education. This is a more student-centred approach to learning where negotiation becomes important between the two parties, and learner and teacher acknowledge the concept of lifelong learning (Horsfall et al., 2011). Horsfall et al. suggest that the teachers’ role includes facilitation, active engagement, trust development, and role modelling constructive and interaction styles. While teachers utilise strategies to develop their teaching skills, it is experience that allows them to broaden their role and also reflect on their practice, which becomes integral to teaching practice. Horsfall et al’s commentary emphasised key teacher roles and strategies for teaching nurses in clinical settings; highlighting lifelong learning, reflection and the importance of teacher-learner negotiation. While Horsfall et al. (2011) did not address the educational preparation of clinical facilitators, one could logically expect that a student-centred approach to facilitation, encouraging life-long learning, reflection, and incorporating experiential learning would comprise important elements of effective supervision.

While there are a large number of learning theories that compete in education (Minter, 2011), it is important to understand whether learners and teachers are cognisant of learning principles. Understanding students as adult learners is integral to teaching within universities, including undergraduate student nurses. Adult learning principles include self-directed learning, which is a major learning theory also advocated by a number of theorists including Brookfield (1986), Candy (1991), Knowles (1984), Knowles, Holton III, and Swanson (1998), Merriam and Caffarella (1991). These scholars all consider that the learner takes the initiative to control what they want to learn and how they want to acquire knowledge. Scully (2011), who writes from a student perspective, argues that while the clinical facilitator plays a role in linking theory to practice and socialisation of students to the clinical practice areas, students also have to be responsible for their own learning through the use of reflective practice. Most Bachelor of Nursing programs include reflective practice and active learning, and some use problem-based learning or, more recently, solution-focused learning.
(McAllister, 2003), which is explained in the following section. Scully (2011) posits that the student must be motivated to use reflection and self-directed in their learning.

Commentaries on teaching and learning are enormous, covering diverse fields relating to psychology, sociology and exploring issues of pedagogy, curricula and assessment. Because of the constraints of this thesis this literature focuses on studies relevant to facilitator / student relationships and problem based learning. It is important that the clinical facilitator understands the principle of self-directed learning and individual needs of each student in tailoring learning experiences. The clinical facilitator should also have an understanding of different learning styles so that they can assist students learning while assisting the transformation of a meaningful clinical experience. Kolb (1984) argues that clinical facilitators should have an understanding of their own learning styles, so they are better equipped to understand the students’ needs. While some clinical facilitators base their teaching on their own learning styles, the literature is unclear about how this influences their approach to facilitation.

Some clinical facilitators have completed their education through problem based nursing courses, where the expectation is that the student learns about a subject through the experience of problem-solving (Hmelo-Silver, 2004). Within problem-based learning, the student nurse needs to recognise their knowledge deficits and, with the guidance of the facilitator, work through the problem at hand. Another form of learning is solution-focused where instead of the focus being the problem the focus is on the solution. According to McAllister, Moyle, and Iselin (2006) while solution-focused nursing is an alternative approach to nursing, rather than traditional nursing where the problem is central to care; many teachers are unfamiliar with the context and thus require further education. Where this approach is used, it is important that clinical facilitators understand the implications for meeting the students’ learning needs. Implications for the traditional problem-based learning are that learners are ill-prepared to be proactive in their application to learning whereas in a solution focused situation the learner uses logic and creativity, deductive and inductive thinking, imagination and
reason, problem-solving and solution searching (McAllister et al., 2006). These are concepts that take considerable time and study to fully understand, and incorporate into one’s own teaching repertoire.

In addition to changes in the models of education, characteristics of the learner have also changed in the last 30 years (Tennant & Morris, 2001). Historically, the majority of higher education students entered university straight from school with no exposure to previous tertiary education (Archer, Cantwell, & Bourke, 1999, 2001). In more recent times, greater numbers of students completing vocational diplomas are upgrading to tertiary qualifications, perhaps in response to societal changes (Bradley, 2008). The Bradley Report (2008) highlighted that Australian students are highly diverse and changing rapidly, therefore the educational sector must change to keep up with their needs (Bradley, 2008). An Australian study by Cantwell, Archer, and Bourke (2001) also suggests that there has been a shift in the composition of undergraduate students in universities, including the increase in mature age students, with women forming a high portion of the increase. This increase in women entering higher education is relevant to nursing, which traditionally has been a female dominated profession since the Nightingale era. Australian statistics show a progressive increase in the number of students, particularly female students commencing higher education from the years 1985-1993 (DETYA, 2001) which coincides with the move from hospital trained nurses to university education.

There are a number of factors that influence the mature-age learner’s successful transition to higher education. These include the fact that, historically many older adults have had less formal schooling than their younger counterparts (Lorge, McClusky, Jensen, & Hallenbeck, 1963). There was often less opportunity to continue at school in earlier times and going into the workplace was the most readily available option. Moreover, there was often a lack of requirement for a comprehensive initial preparation for the high-level certification now required by some occupations. So, not only did older adults not have access to educational provisions, there may well have been no imperative for them to do so. Therefore, some older members of the population appear to have been disadvantaged not only because of the
remoteness from formal schooling (Lorge et al., 1963), but because they had fewer opportunities to attend university when they first commenced nursing. With the transfer of nursing into the university sector, these older students are now considering higher education to become registered nurses. Mature aged students have unique needs, particularly in terms of having to reframe self-understanding of their existing knowledge (O'Donnell & Tobbell, 2007). Re-entering education typically provides the impetus for them to reflect on their actions, which may be a new experience to them.

Summary of literature

Clinical placements are crucial for student nurses to develop their clinical practice skills. There are, however, few published studies that examine the dimensions of the clinical facilitators’ role and clinical facilitators educational preparation (Forbes, 2010). While there is literature available in relation to clinical supervision, little is known on what constitutes best practice in clinical facilitation of undergraduate nursing students undertaking group placements. Much of the literature is from the United Kingdom, Canada and the United States of America with limited Australian studies.

There is consistency in the literature in the expectation that the role of clinical facilitator is aimed at linking theoretical knowledge to clinical practice (Lambert & Glacken, 2005). The literature to date tends to focus on learning outcomes, student perceptions of their clinical learning environment (Dunn & Hansford, 1997), student knowledge and competence, a general description of the facilitator role, and the responsibilities of stakeholders (Health Workforce Australia, 2010). While there has been some phenomenological research into the experiences of the clinical facilitator, there is a lack of understanding of the clinical facilitators’ knowledge and expectations of the role. Although Sanderson and Lea (2012) outlined various aspects of the clinical facilitators’ role, they have not identified barriers to the role or aspects that the clinical facilitators themselves have highlighted as enabling them to perform the role to the best of their ability.
Inconsistent terminology when discussing clinical facilitators, clinical teachers, clinical supervisors and clinical facilitation of undergraduate student nurses blurs understanding and creates confusion of the roles. Little is known about the perceptions of the clinical facilitator and their understanding of their role in clinical facilitation. The literature review has highlighted that further research is needed to address the perceptions of the clinical facilitators in understanding what they perceive best practice is in relation to the facilitators’ role, clinical facilitation and the educational qualifications when they commence in the role as a clinical facilitator. An Australian study should identify common and unique clinical facilitator perceptions and assist understand the role that the clinical facilitators play in student nurse education. Universities need to understand and support clinical facilitators’ needs and find resources that they may require to assist them in the development of efficient, effective and appropriate nursing students who will be the next generation of nurses. This study will address the gap by asking facilitators who currently undertake the role to reflect on their practice and consider how they have developed as clinical facilitators and what they consider the basis for describing best practice. The findings will advance knowledge of best practice of clinical facilitation by identifying what current clinical facilitators perceive as best practice. The next chapter outlines the research method used for data collection in the study.
CHAPTER 3: METHODOLOGY and METHODS

Introduction

This chapter describes the conceptual and methodological underpinnings of the study. It outlines the method and design, the procedures used for data collection and the choices of analytical methods for the study. Methodology is an overall approach with the logic, potentialities and limitations of the research methods (Grix, 2002; Mackenzie & Knipe, 2006). Therefore, the methodology addresses how the research acquires knowledge (Denzin & Lincoln, 2005; Schneider, Whitehead, Lobiondo-Wood, & Haber, 2013), whereas the method includes the precise procedures I used to acquire the data. The study is an interpretive, naturalistic case study conducted in the context of clinical facilitation in practice.

Interpretivism

The interpretive paradigm is underpinned by the researcher relying on the participants' views of the situation being studied; an approach deemed appropriate when little is known about the issue (Schneider et al., 2013). Weaver and Olsen (2006) integrative review outlined frequently used nursing paradigms. The positivist paradigm based on rigid rules of logic and measurement, truth, absolute principles and prediction (Weaver & Olsen, 2006) is used in quantitative research was not considered suitable for the current study. Another paradigm highlighted by Weaver and Olsen (2006) is the critical perspective also known as the critical social theory paradigm which addresses social issues including cultural, political and economic factors. In comparison, Interpretivism aims to understand the values, attitudes and beliefs which influence the actions of people where events and situations are fluid. From these understandings the researcher can interpret meanings and perspectives (Mackenzie & Knipe, 2006; Schneider et al., 2013).

Interpretive studies rely on the interactions between the researcher and those being researched. I interacted with the participants in a way that
explored many possibilities for interpreting their insights through questions and prompts to clarify what they meant in the context of interactions, and then reflected on my interpretations. These processes respond to Schneider et al. (2013) explanation that the “goal is that the researcher has a deep and self-reflexive engagement with the phenomena being studied” (p. 25). This interpretive approach was intended to generate meaning and a sense of the perspectives of the clinical facilitators on best practice in clinical facilitation through reflection from both the participants and myself.

**Conceptualizing the study**

The idea to research best practice clinical facilitation of undergraduate nursing students evolved from my thinking about and reflecting on the clinical facilitators that were employed in the School of Nursing and Midwifery at Griffith University and the fact that there was no evidence base to help guide them for the role or to inform educational strategies to prepare them. Yet, they were familiar with the notion of best practice, which has become part of the nursing lexicon throughout the past decades. It was clear to me as a coordinator of clinical practice, but hadn’t yet been demonstrated in research that most facilitators were using reflective practice in their approach to working with students. Their reflective approach was evident in the workshop interactions that prepared them for the role. My interactions and workshop discussions with the facilitators indicated that they were framing and reframing their expectations on previous experiences in a way that balanced their prior clinical knowledge and experiences with the expectation of the school and University. This led me to premise that Schon’s theory of reflective practice may be appropriate as a theoretical framework for the study, particularly as it was my intention to explore best practice from the facilitators’ perspectives.

Schon’s theory has become popular in a number of nursing studies. According to (Taylor, 2000) reflection is based on life and two key main human interests of *being* and *knowing*; where knowing how to reflect is a process for making sense of all life experiences and being able to do
something for oneself; in the current study, being able to reflect on life experiences. In everyday life, learning is not always deliberate and sometimes there can be accidental discoveries through reflecting on the experiences and outcomes of what has occurred. Another consideration relevant to the study was to identify the barriers that may prevent the experience or the process of reflection and ways in which the clinical facilitator can enhance the learning experience. This study adopts a reflective practice stance to the enquiry of what constituted best practice clinical facilitation for undergraduate nursing students. Participants were encouraged to reflect on their experiences as clinical facilitators, considering how they first commenced in the role and describing how they facilitated and the experiences that they had during their time as clinical facilitators. With encouragement the focus group participants interacted with one another and with me, as the researcher.

As a researcher I began to search for other studies on clinical facilitation and to review alternative ways of conceptualising practice. My literature search revealed little evidence of the facilitators' role and only limited studies explaining facilitators' perceptions of their role, none of which were framed within Schon’s theory. In addition to the overarching question of what they believed to be best practice, I assumed that the clinical facilitators would have some common perceptions on barriers and enablers to best practice, and views on appropriate educational preparation for the role as well as personal and professional characteristics that would contribute to performing the role at a ‘best practice’ level. I was interested also in what had influenced these registered nurses to move away from a clinical role caring for patients to a teaching role educating undergraduate student nurses and therefore included a question on what attracted them to the role.

Each of these questions (see pp 18 -19) required participant perspectives, which would be analysed within Schon’s theory of reflection-in-action and on-action. To answer the research questions would require a reflective approach. The study was therefore conceptualised within the theory of reflective practice (Schon, 1983). Reflective practice is the activity of deliberating and considering what has happened, how something has
transpired, and whether what has been done could have been done better or in a different manner (Heath, 1998). While reflection has been described by many scholars, two main concepts interrelate to active learning or experiential learning. These concepts are reflection-in-action, which is “described as a process of thinking about something while you are undertaking the task” and reflection-on-action which is considered to be “the process of analysing something after the event or task has happened” (Schon, 1983, p. 54).

This methodological approach to the study was developed from this theoretical framework. First, through the development of concept maps prior to the focus groups, the clinical facilitators were given the opportunity to explore their knowledge of the role of the clinical facilitator and write down their thoughts. Reflecting on the role allowed them to provide a greater awareness of what they understood of the role. The concept maps had six categories which guided the clinical facilitators; each of which was developed from the study aim, the research questions and the literature. Concept mapping was informed by Taylor’s (2006) work with reflective practice in nursing. She identified different formats of reflection including drawing, painting and montage as a way of mapping ideas. In the current study concept maps assisted the clinical facilitators to link their ideas on clinical facilitation through diagrams which assisted in providing insight for the focus groups. Schon (1987) and Taylor (2006) suggested that when a person is encouraged to think about their ‘knowing in action’, particularly in illustrating their knowledge and how it is used they inevitably develop deeper awareness and understanding to ultimately change their practice. Schon (1987) referred to tacit knowledge or knowing in action, as the kind of knowledge that a person may not be entirely aware of. Concept maps have been described as a useful tool used to clarify ideas and show understanding of meaningful relationships and associations of concepts and ideas (Schneider et al., 2014). The concept maps were used as a strategy to help guide them towards self-understanding; that is, to become more reflexive in considering best practice in their role. Following this phase, they were encouraged to use
these ideas in the context of focus group discussions and individual interviews.

Participants’ reflections formed the core content of a case study. Case study allows the researcher to investigate contemporary issues when boundaries between the issue and context are not clearly evident, the understanding of real issues through reflection assists the researcher to consider all aspects of particularisation.

The case study approach

Case studies are used to research a variety of social sciences (Ragin, 1992; Yin, 2009) including healthcare, to explore, describe and analyse problems and phenomena of interest about people and/or programs to yield in-depth understanding about situations, typically in real life circumstances (Luck, Jackson, & Usher, 2006; Stake, 1995). As a form of research, case study is defined by Denzin and Lincoln (2005) as “an interest in an individual case, not by the methods of inquiry used” (p. 443). According to Merriam (1998) case study research can refer to the process of doing a case study, the unit of analysis, that is the particular ‘case’ under discussion, or the end product. The term is therefore used in many ways by researchers across disciplines. Discussions of what case study ‘is’ or ‘involves’ often focuses on the issues relating to the ‘nature’ of a case and how the case study itself is conducted.

Case study allows the researcher to study a single or multiple cases in bounded systems which are of particular interest to the researcher. Yin (2009, p. 18) considers a case study “an empirical inquiry that investigates a contemporary phenomenon within its real-life context”. Stake (1995) categorises three types of case study, including intrinsic, instrumental and collective (Stake, 1995). The intrinsic case is when there is an interest in what is happening, and there is a need to learn about a particular case in question for its own sake (Stake, 1995). The instrumental case is guided by a research question where the researcher wants to elicit a general understanding of the
problem by studying a particular case or the issue at hand, so the researcher endeavours to gain insight into the issue or problem. Collective case study considers several cases rather than just one attempting to address an issue in question. Usually the latter design involves several instrumental cases (Hancock & Algozzine, 2006). Stake (1995) suggests that a study may commence as either intrinsic or instrumental and the two may meld.

This case study of what constitutes best practice clinical facilitation is an instrumental in nature and draws on multiple sources of primarily qualitative data to answer the research question asked for general understanding by prompting participants for their perspectives in the particular context of clinical facilitation of undergraduate nursing students. Stake (2006) explains that understanding qualitative research is the ability to learn from doing or seeing an event or issue (the case) within a particular situation. The aim of the study was to explore and understand clinical facilitation as a particularisation, understanding the common and unique elements of each individual’s perspective of the case, rather than generalisations about other cases. According to Stake (1995):

“we study a case when it itself is of very special interest. We look for detail of interaction with its contexts. Case study is the study of the particularity and complexity of either a single case or multiple cases, coming to understand its activity within important circumstances”.

Stake’s (1995) approach to case study requires the researcher to elicit three things. First, who/what was the case? Second, what was the issue, and third, what was the context? In this study, the case was comprised of the perspectives of eleven clinical facilitators, bounded as a single case employed as clinical facilitators for Griffith University. The intention of studying this case was to know and understand the particular case, including its uniqueness, problems and concerns (Stake, 1995). The context for this study was the practice of clinical facilitation in South East Queensland universities. As in other qualitative studies, the context captures the features that are specific to a particular setting, including the place, time and
circumstances (Roberts & Taylor, 1998). The findings will inform what constitutes best practice from the clinical facilitators’ perspective through their reflection on their experiences as clinical facilitators. The significance of these findings will be to understand and articulate how the clinical facilitator provides best practice to contribute to the successful completion of clinical placements. This information will ultimately advance knowledge of pedagogical processes for improving nursing education.

The Role of the Researcher

In interpretive studies, including case study research, the researcher is instrumental to data collection and analysis. As a former clinical facilitator and current professional practice (clinical) coordinator, I have had many years of clinical experience across Queensland and South Australia, and extensive background knowledge of clinical placements and the role of the clinical facilitator. I was employed as a clinical facilitator between 1992 and 2001 while also practising clinically in healthcare systems across Brisbane. I was also employed as a clinical coordinator in a joint appointment between a local private hospital and the university, and also as a senior nurse coordinating the hospital after hours and later as the nurse educator for over two years. In 2009, I returned to the university sector and was employed full time in the role of clinical coordinator in a tertiary institution. In that role, I conducted education sessions for clinical facilitators, and conducted interviews to employ facilitators and sessional staff both within the education sector and health care agencies. This considerable experience in the area of clinical placements and clinical facilitation allowed me the ability to engage closely with the participants, identifying, describing and interpreting the data, and reflecting and revisiting the themes to identify their meanings and understandings. While I was able to draw on personal understandings of the role, I have journaled my own reflections throughout the analysis, which were revisited in relation to the findings and discussed with supervisors throughout the study to minimise any bias that may have intruded on the analysis from my experience.
Method

Setting

The study conducted within Griffith University, a single university in the state of Queensland, Australia. The university has three domestic campuses in the South East corner of the state where enrolments in the undergraduate Bachelor of Nursing program total approximately 2200. A convenient location for the focus groups and interviews was negotiated with the participants, at the Logan campus, which provided an ideal setting to afford privacy and accessibility for the participants.

Sample

Clinical facilitators were recruited from the database of clinical facilitators of the university. Clinical facilitators are appointed within the school university via a formal election process and interview. The university maintains a pool of clinical facilitators who are employed casually. Individuals were contacted via email or telephone to ascertain their willingness to participate as volunteers in the study. The sampling strategy was therefore purposive, with access provided through the university School of Nursing and Midwifery. The study required the researcher to have an in depth knowledge of the setting for the research (Creswell & Plano Clark, 2007) and for purposive sampling a knowledge of potential participants. Purposive sampling also required participants to be knowledgeable about the subject, which brought a common experience to the study. As a professional practice coordinator, I had access to the database with permission from the then Head of School. Clinical facilitators had undertaken a range of clinical placements and were therefore considered the best source of collecting rich and valuable information about their perspectives of best practice for the role of clinical facilitator. Inclusion criteria for participants in the study are as follows:

- English speaking
- Registered nurse with the Australian Health Practitioner Regulation Agency (AHPRA),
- Practising registered nurse,
- Minimum of five years’ experience in the clinical facilitation role
- Male or female,
- Clinical facilitator in any health care agency (private or public) or university
- Some clinical facilitators had TAFE experience in the role

The TAFE sector is an educational provider that conducts courses for assistants in nursing and diploma courses for nursing. At the time of recruitment to the study demographic data was collected to obtain age, gender, family and marital status, educational level and employment history to ascertain the diversity of the clinical facilitators within the study. This information may indicate particular relationships between the demographic variables and social variables of the participants.

Data collection

Eleven facilitators volunteered for the study which was conducted in three phases. These were phase one: concept mapping; phase two: focus groups and phase three, individual interviews. The participants were asked to complete a concept map as phase one prior to the commencement of the focus groups and were given a basic outline with a circle for best practice and six empty circles around the central circle, along with six prompts outside the six circles. The structure of the concept maps was provided as a way of helping participants structure their reflections. These prompts were drawn from my assumptions of the role of the clinical facilitator and also from the literature around teaching and learning and student placements. Prompts included; (i) how do we do it; (ii) students characteristics and their lives; (iii) strategies; (iv) influences on knowledge; (v) assessing students, and (vi) liaising with university / health care agencies. Participants were asked to spend about fifteen minutes prior to the focus group discussion jotting down their ideas and linking these in any way they thought relevant. Concept mapping was briefly explained with most participants having said they had previously completed concept maps or had learnt about concept maps while undertaking research courses, during either Certificate IV in Training and
Assessment, Bachelor of Nursing or Master of Nursing programs. The participants were encouraged to continue adding to their concept maps during the focus groups, as a way of linking their ideas as they immersed themselves in the reflective process.

Phase two of the data collection included the two focus groups. Focus groups are effective and efficient with usually five to sixteen persons in the group where the researcher has the opportunity to capture ideas (Polit & Hungler, 1995; Polit & Beck, 2010) and, in this case, the perceptions of the participants in relation to clinical facilitation. During the focus groups participants were encouraged to share their ideas and reflections on the topics outlined in the research questions; that is to explain influences on best practice in terms of barriers and enablers; to identify any influences that attracted them to the role; and their perceptions of appropriate educational preparation, and personal and professional characteristics that influence clinical facilitation. Andrew and Halcomb (2009) also suggest that the focus group allows the participants the opportunity to voice opinions and experiences while the researcher observes the participants interacting and the dynamics of the group. In this study, I asked the clinical facilitators to reflect on their practice so that I could gain an understanding of their perceptions of the role, and explore their understanding of how the clinical facilitators learn. Focus group participants were prompted to reflect on events and influences that helped shape their knowledge of clinical facilitation.

The first focus group had six participants and the second group five, in which I asked a small number of open-ended questions which were intended to elicit the views and opinions of the participants. I conducted the focus groups in a pre-arranged room to allow easy access for all participants and to provide privacy to ensure that the group was not interrupted. The first focus group had a research supervisor attend as a non-participant observer. I took limited field notes during the interviews and focus groups to avoid distracting the conversation or altering the flow of the interview (Gay & Airasian, 2003). I recorded the names of each respondent when they were speaking to assist me to concentrate on the dialogue, manage the group, and make sure that all members had the opportunity to give their views. The participants and I
signed consent forms prior to commencement of the focus group and individual interviews. The participants were given a verbal explanation by me about the study at the beginning of the focus groups and a further explanation at the commencement of the individual interview. Broad questions used for the focus groups are listed in Appendix A.

To decrease the risk of individual clinical facilitators monopolising the discussion during the focus groups, I acted as a “gate-keeper” as described by Schneider, Whitehead, Elliott, Lobiondo-Wood, and Haber (2007, p. 129) to ensure that quieter members were given the opportunity to participate in the discussion, thereby avoiding “group think” outcomes. At the completion of each of the two focus groups the participants were asked to volunteer to participate in an individual interview with me to elicit further understanding of their perceptions of the role of the clinical facilitator. While all participants volunteered verbally after the focus groups to undertake an individual interview, after discussion with supervisors of the study it was decided that a maximum of six participants would be a sufficient sample to undertake individual interviews. Data were collected using a modified set of questions adapted from Scanlan’s (2001) study. As discussed in Chapter 2, Scanlan’s research considered how the clinical facilitator learns to be a clinical teacher; she used five questions conducting individual interviews with 2 groups of clinical teachers. Group 1 who had less than 2 years’ experience and group two who had greater than 5 years’ experience as clinical teachers. There were nine interview questions for the current study that were open ended with the length of the interviews taking between 30 minutes and one hour (see Appendix A). The final question asked the participants their opinion of what they considered constituted best practice in clinical facilitation, whereas Scanlan’s research considered how the clinical teachers learned their role and the differences between novice and expert clinical teachers.

A script was developed for the individual interviews also focusing on their reflections see Appendix A. The questions were developed after the focus groups with the interviews taking place about 5 -6 weeks after the concept maps and focus groups. This time span allowed the clinical facilitators the opportunity to reflect on their participation in the focus groups.
and their role as clinical facilitators prior to undertaking the interviews. Individual interview participants were encouraged to adopt a reflexive stance again to explaining their perceptions of best practice. They were encouraged to immerse themselves in their reflections. This reflexive thinking about their experiences was expected to generate discussion and encourage critical awareness about clinical facilitation to develop strategies and understanding of the clinical facilitation role in the social context.

The interview questions as included in Appendix A prompted them to talk about their clinical facilitating in their own word; to explain how it has changed over time and what factors have influenced those changes over time. The question of what attracted them to the role was also included in this phase. They were asked how they learned about clinical facilitation, in particular what education they had received to undertake the role. The interviewees were also asked to describe some of the changes they have made in their facilitating over time, what barriers, strengths and constraining factors they had encountered. At the end of the interview they were asked the global question of what they believed constitutes best practice in clinical facilitation.

The individual interviews took place after the preliminary analysis of the focus groups at times convenient to each participant and myself. The clinical facilitators were sent the questions via email prior to the interviews to give them the opportunity to consider, and reflect on clinical facilitation. Each clinical facilitator received the same questions; I offered to clarify and elaborate on any of the questions or explain expectations of the study via phone or email prior to the scheduled interview and again at the time of interview. Participants were questioned in depth about their facilitation experiences. I had the opportunity to clarify and explore answers with participants to assist with understanding the participants’ perceptions of the issue. One participant elected to have the individual interview conducted via telephone for her convenience. During both the focus group and individual interviews I had the opportunity to write down key words to further explore answers the participants gave so as not to interrupt and distract their train of thought.
Data management

Data were collected in three phases. Phase one occurred at the outset of the focus groups and consisted of concept mapping as mentioned previously. Data management was systematic as a large amount of data was generated from the focus groups and individual interviews. The task of collecting and managing the data was intended to be transparent so that it remained clear what has been undertaken. I kept a diary of important information including calendar of events and observational notes. Names of participants and phone numbers are kept separate in a locked cupboard.

The focus groups were digitally recorded and transcribed to ensure accuracy of data. Transcription was completed contemporaneously to increase the credibility of the findings and indicate any areas where further data should be collected. The individual interviews like the focus groups were digitally taped and transcribed again to ensure accuracy of data, including the date, time and location of the interview. For each line of all the transcripts, numbers were apportioned for easier identification when interpreting the data. Transcripts were completed after each interview and each participant identified by a pseudonym. Once interviews were transcribed the participants were asked to read their accounts to ensure accuracy. Once this had been completed, to ensure anonymity, identification was removed and the audio data destroyed once the transcription was complete.
### Table 3 - 1 Data Sets

<table>
<thead>
<tr>
<th>Phase</th>
<th>Method</th>
<th>Number of participants</th>
<th>Type of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Concept Map</td>
<td>11</td>
<td>Concept maps x 11</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Focus Groups</td>
<td>2</td>
<td>Transcripts x 2 sets, thematically analysed</td>
</tr>
<tr>
<td>Phase 3</td>
<td>Individual Interview</td>
<td>6</td>
<td>Transcripts x 6 sets, thematically analysed</td>
</tr>
</tbody>
</table>

**Data analysis**

The analysis began with thematic analysis of focus group data. Thematic analysis is “a method used to identify, analyse and report patterns (themes) within the data” (Braun & Clarke, 2006, p. 79). Braun and Clarke (2006) identify one of the benefits of thematic analysis as its flexibility to provide a rich and detailed, yet complex, account of data, which occurs by finding relationships between ideas and how these link together (Saldana, 2009). For this study the process of categorising and re-categorising through several iterations was designed to reduce data into meaningful themes.

The two focus group transcripts were analysed separately using techniques recommended by Braun and Clarke (2006). The first step in the process was the transcription of the focus groups within one week of being conducted. The transcripts were read in an interpretive manner, looking for significant statements that were associated with the study objective – to understand the perceptions of the participants about best practice in clinical facilitation. After the initial impressions, categories were developed from the data of each focus group on the basis of repeated concepts arising in the conversations. The two transcripts were compared using constant
comparison, by going back and forth through the data and noting provisional categories and themes with each iteration. While there are computerised systems for analysis I decided that for this study, the data would be analysed manually to enable me to engage deeply with the themes emerging from the analysis. Once the focus groups were analysed and themes identified, I conducted the face-to-face interviews with the clinical facilitators to further explore the clinical facilitators’ perceptions and answers from the focus group.

At the conclusion of the focus groups participants were introduced to the concept mapping phase of data collection. According to Schneider et al. (2007) concept mapping assists the researcher to develop ideas and understand relationships between the issues and in this particular study assisted to find links allowing the facilitators the opportunity to consider their perceptions of clinical facilitation. Concept maps are considered to be organisational tools which researchers use to clarify data (Gul & Boman, 2006). The concept maps assisted in identifying key words about clinical facilitation giving a visual representation of the ideas and providing a picture of how the clinical facilitators viewed their role. The use of concept maps is considered to enhance the analysis of data, connect ideas and allow for representation of issues that have not been combined in such a way before (Gul & Boman, 2006; Kane & Trochim, 2009).

As individual clinical facilitators’ interviews were completed, the data were transcribed. I then commenced thematic analysis using the same approach as with the focus groups. Each transcript was analysed separately by reading and re-reading, to understand the clinical facilitator practices and to identify them as individuals. An interpretive analysis was conducted to identify categories and themes in participants’ responses. Each transcript was compared and contrasted throughout the process of being read and re-read, through several iterations as a form of data reduction. Through the first stage, I listened to the tapes several times and read each transcript many times becoming immersed in the data. Common words, phrases and statements were then extracted as a basis for formulating meanings. While analysing the transcripts separately the cases were also compared across
the cases to identify patterns looking for instances of the same comments and also any instances that seemed contradictory. Interpretations and patterns were then verified with members of the supervision team. I identified meanings in the data, by interpreting, dissecting impressions and observations as recommended by Stake (1995).

During analysis of the transcripts I identified and combined categories and headings to compare emergent themes. Interpreting the data into categories ranged from a single word to a full sentence or paragraph to an entire page of text (Saldana, 2009) where the theme represented the primary essence of the content of the data. In the study I continuously moved between the text as a whole and individually through stages or cycles as noted by Saldana (2009) and Stake (1995). The demographic data were described and particularized to outline the participants’ demographic characteristics in the findings. This information includes their previous experience and educational preparation for the role as part of the demographic profile to identify patterns that have influenced these factors on their perceptions of best practice. It was expected that there would be some differences in their education, staff development and length of time they had worked as facilitators, whether or not they had worked for multiple universities, and with different levels of students or in different clinical areas. Therefore although it was expected they would have the common experience of having facilitated students (and on this aspect they are homogenous) I remained open to any variability in education and experiences.

**Ethics**

Ethical consideration is essential to all forms of enquiry. Ethical approval for the study was obtained via Griffith University Human Research Ethics committee GU Ref No: EDN/55/13/HREC see Appendix B. This research was informed by current guidelines provided by the National Health and Medical Research Council (NHMRC, 2007). Awareness of power relationships is essential in any research, and as I had previously employed a number of the potential participants’ special care was taken to avoid any
perception of coercion for them to participate (Holloway & Wheeler, 2010). All potential participants were assured that I would have no involvement in their employment, which was achieved by ensuring that another professional practice coordinator at the university took over responsibility for employing all facilitators across the university for the period of data collection.

The primary consideration was to ensure confidentiality was maintained. An assurance of confidentiality despite the lack of anonymity (because all participants were known to the researcher) was explained and assured to the participants prior to the commencement of the study. On agreement to participate in the project, the study was further explained to the participants verbally and the consent forms signed by the participant and myself (see Appendix C). All information collected from participants was voluntary, confidential and used for the purposes of the study only. All personal details were removed from the data to ensure participant anonymity and, as mentioned above, each participant received a pseudonym. Participants were assured that they could withdraw from the study at any time or refuse to answer any question without resulting in any negative consequences (Flick, 2008). All de-identified data is being kept in a secure filling cabinet separate from the participants’ personal information. For this study voice recordings were carefully and fully transcribed with date and time, all focus groups and interviews were undertaken at the same location, and the pseudonym of the interviewee has been placed on the front page. Several copies of the transcripts were made with a clean copy locked away for safe keeping throughout the duration of the study. Raw data documents will be retained according to the National Health and Medical Research Council (NHMRC) guidelines for a period of 5 years after the completion of the research (NHMRC, 2007). At the time of recruitment to the study demographic data was collected to obtain age, gender, family and marital status, educational level and employment history to ascertain the diversity of the clinical facilitators within the study. Once the participant had agreed to be involved in the study, data collection commenced.
Rigour

Credibility and trustworthiness are important elements in maintaining rigour in interpretive research (Denzin & Lincoln, 2005, Schneider et al. 2007). Trustworthiness encompasses credibility, dependability, transferability and confirmability. According to Schneider et al. (2007) credibility is “truth of findings as judged by participants and others within the discipline” (p. 149). Credibility may be compromised if the researcher allows biased views to influence findings of the study and conclusions (Yin, 1994, 2009). To maintain the credibility of this study I selected participants who had had greater than five years’ experience with clinical facilitation, and used member (participant) checking where participants were asked to check their transcripts for authenticity and to ensure fittingness of the analysis with their experiences.

The dependability of the study was maintained through providing a clear account of the research process which allowed others to follow my thinking and conclusions about the data which, according to Polit and Beck (2012) would allow them to assess whether the findings are reliable. I also maintained a journal of reflections and thoughts which were reviewed in collaboration with supervisors to eliminate any personal bias. Documenting study procedures and findings in an audit trail maintained trustworthiness of the study as suggested by Denzin and Lincoln (2005).

Transferability as a context of trustworthiness includes fittingness, faithfulness and detail equivalent to external validity in positivist research (Schneider et al., 2013, p. 399). The researcher’s role is to provide detailed information that allows readers to make inferences about the findings of research in relation to other settings. The readers of research are the ones who decide if one research case can be transferred to another setting assessing the extent to which conceptualisations and findings could apply to new situations; that is, whether they are confirmable (Polit & Beck, 2012).

According to Polit and Beck (2012) confirmability refers to “objectivity, that is, the congruence between two or more independent people about the data’s accuracy, relevance or meaning” (p. 585). This criterion assists to
establish that the interpretations of the findings are acquired from the data provided by the participants rather than the researcher’s bias or perspectives.

The focus groups, interviews, concept maps and demographic data produced multiple sources of evidence that enabled what Yin (2009) calls converging lines of inquiry. Converging lines of inquiry is also referred to as triangulation which, in the research context, is used to describe the use of a variety of data sources or methods to converge on an accurate representation of reality (Polit & Beck, 2014; Schneider et al., 2013). Data from each source was compared to ensure rational decision making throughout the research process (Denzin & Lincoln, 2005; Stake, 1995; Yin, 2009).

Summary

In summary, this chapter provided the framework and procedures critical for obtaining and analysing data, which assisted with understanding best practice of clinical facilitation from the perspectives of eleven experienced clinical facilitators through focus group and face-to-face interviews. The case study of the clinical facilitators has provided an understanding of the perceptions of the clinical facilitator in relation to best practice and educational requirements. While the collection of copious amounts of data had some limitations, the data were analysed through coding and categorising themes and patterns arising from all three data sources: focus groups, interviews and concept maps. Interpreting relationships amid the themes allowed for a deep analysis of the data collected. Case study was considered the most appropriate method for the study as it focused on contemporary issues and did not require control of behavioural events. Focus groups and individual interviews with the eleven clinical facilitators allowed me to focus on the facilitators’ perceptions and what they considered to be best practice. This included the facilitators’ own educational experience for the role of clinical facilitator and how they have changed as clinical facilitators over their time in the role. Findings from the
interpretive analysis of the focus groups, individual interviews and concept maps are reported in Chapter 4.
CHAPTER 4: FINDINGS

WHAT CONSTITUTES BEST PRACTICE CLINICAL FACILITATION: ‘THE BEST POSSIBLE EXPERIENCE’

Introduction

As outlined previously, clinical facilitators were invited to participate in focus groups to reflect on their practice and discuss their perceptions of what constitutes best practice in clinical facilitation of undergraduate nursing students in health care agencies. The analysis focused on the participants’ reflections of their role as clinical facilitators to identify issues to inform future practice, education and research using the reflective model of Schon (1983) to guide the research. As previously reported reflection is the activity of deliberating and considering what has happened, how something has transpired, and whether what has been done could have been done better or in a different manner. Eleven registered nurses participated in the focus groups; all of whom were experienced clinicians with more than five years’ experience as clinical facilitators. Ten of the eleven clinical facilitators in the focus groups indicated that they had been registered nurses for over 25 years, with only one having between 16 and 25 years’ experience. All but one were female, and the male nurse had 25 years of experience and had completed a Bachelor of Nursing to gain an academic qualification. He became a general registered nurse and practised as a general nurse for a few years before returning to mental health nursing. The age range of the clinical facilitators was 37 to 66 with the average 54 years of age. Focus group one participants included one mental health nurse, an RN who had a paediatric background, and four generalist clinicians. Coincidentally, focus group two also included a mental health nurse and an RN who had a paediatric background, as well as an intensive care specialist, an oncology specialist and a generalist with a background in midwifery.
Table 4 - 1 Participant demographics (N=11)

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Years of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>16 - 25</td>
</tr>
<tr>
<td>37 - 49</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>50 - 59</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>60 - 66</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

This chapter presents the main findings of the focus groups as themes and subthemes (see Table 4.2) followed by a summary of the concept maps. Best practice clinical facilitation in this study comprised the following elements: Assessing, Learning to Facilitate and Facilitating Effectively, with subthemes identified under each theme. The first theme assessing comprised the following subthemes: assessing general needs, assessing student specific needs, assessing the local environment, and matching up. Second, the theme learning to facilitate comprised four subthemes formal preparation, maintaining knowledge, and networking. The third theme facilitating effectively comprised interacting and communicating effectively, being supported and exemplars of best teaching practice: the uniqueness of clinical teaching.
Table 4 - 2 Themes and sub-themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub - themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing</td>
<td>Assessing general needs</td>
</tr>
<tr>
<td></td>
<td>Assessing student specific needs</td>
</tr>
<tr>
<td></td>
<td>Assessing the local environment</td>
</tr>
<tr>
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<td>Matching Up</td>
</tr>
<tr>
<td>Learning to Facilitate</td>
<td>Formal preparation</td>
</tr>
<tr>
<td></td>
<td>Maintaining knowledge</td>
</tr>
<tr>
<td></td>
<td>Networking</td>
</tr>
<tr>
<td>Facilitating Effectively</td>
<td>Interacting and communicating effectively</td>
</tr>
<tr>
<td></td>
<td>Being Supported</td>
</tr>
<tr>
<td></td>
<td>Exemplars of best teaching practice: The uniqueness of clinical teaching</td>
</tr>
</tbody>
</table>

Assessing

*Assessing general needs*

Assessment was identified by the participants as the priority in the initial stages of clinical facilitation. Participants identified that clinical facilitation was a staged process where they would initially spend time assessing student needs in relation to where the placement was to take place; that is, identifying the local conditions of the health care agency. They suggested that this assessment was undertaken in preparation for matching the students with the local resources required to meet the students’ learning needs. The facilitators also described the clinical facilitation processes they had developed from experience. For example, one of the participants recounted that before she commenced clinical facilitation for any placement she would assess what she required on day one as a basis for planning. The
assessments included considering her previous experiences and resources in relation to the students she had been allocated by the university:

When I first get my package I first look at the year level and I have on my computer orientations for first, second and third years which I then structure for the area that the students are going to. So I start planning from then; what I am going to do on the first day, how much time we are going to spend talking and making them feel comfortable before we go to the ward, because first years need a lot more - they need to be mothered the first day; whereas third years search and find. [I tell them] – go and find everything you need to know, you have an hour to do that and this is what I expect. I prepare the seek and find document at home (FG one, generalist).

Other facilitators agreed that they undertook this overall assessment process to be better prepared for the first day of placement. Another participant agreed that she too would orientate the students in this way to the clinical environment, ensuring that she assessed the student needs considering whether the student was a first, second or third year.

I want to know what year they are at, to begin with, I want to know all the basic things and where they have been prior to or have they been out on a clinical placement? (FG one, generalist)

**Assessing student specific needs**

The group discussion on student orientation and assessment was informative yielding insight into how facilitators attend to the needs of specific students. This was particularly so for students in year one and three of their program. Participants described a process that they had developed where they questioned the students to assess their knowledge and previous experience in the health care industry. This step was considered essential to helping the facilitator assess the students individually in that context, and plan how (s)he would provide the students with a meaningful clinical placement experience tailored to their particular needs. The participants
explained the continuum of facilitation from when they first interact with students to the completion of their placements. As one outlined:

_I get to know the students to find out where they are at; we get minimal information about their year level what courses they have done to date. But I specifically ask them about what their accomplishments are; what they see their strengths and weaknesses are…so those goal setting sort of things, and I ask them to do that themselves…ask them about their expectations of placement…what they feel they need to learn or want to learn and to think about the placement_ (FG two, Oncology specialist).

Undertaking assessment for best practice clinical facilitation was approached by considering student characteristics, including personality, level of learning and what the student wanted to gain from the placement. Participants also explained that they found each student or student group unique. As one participant detailed:

_I always ask them because it’s such a different field, mental health. The first thing I ask them…tell me what you would like to see, what you think you would like to see, what you want to know more about, because that fear is ever present. You know as soon as you mention mental health everybody becomes a little bit anxious…am I going to see somebody who is acutely psychotic who might be aggressive to me? Am I going to be attacked? These are the things, and you feel privileged to be a facilitator because every group is different, and you have a new experience with them and you start from scratch again. You come with your experience and at least you are able to reassure the student_ (FG one, Mental Health specialist).

This excerpt exemplifies how clinical facilitators enacted assessment that was student centred, gaining a clear sense of what they were keen to learn. This particular facilitator underlined the importance of being sensitive to mental health issues, which demonstrates how she enacted assessment for best practice clinical facilitation. She explained the need to have realistic expectations of the students practice based on understanding the students’
level, knowing their scope of practice and also what needed to be assessed. As she went on to comment:

“You build a new strategy every time you meet a group of students…their needs are different; you look at their needs…and their fears, especially in mental health. Some have never seen a mental health client and they don’t know what it is like…you spend quite a bit of time reassuring them and making them understand that it is nothing really to fear. Just giving them some more knowledge…so the first thing is to just look at their needs; this is what we do in mental health, so that we can increase their confidence once they get onto the ward (FG one, mental health specialist).

When asked for clarification on whether the clinical facilitators treated the year levels differently the participants said that they identified and explained the scope of practice and year level to the registered nurse (RN) buddies, and considered it important to make this distinction. Despite conveying the scope of practice of each student year level to staff, there were often unrealistic expectations placed on the students by the buddy nurses, which had to be addressed by the clinical facilitators. As one participant explained:

*Especially second year…a lot of the RNs expect second years to be fairly capable, and I have to say ‘do you realise that they are baby nurses’?, because for some of them it is the first time that they have been in a hospital, let alone touched a tablet and you’re expecting them to function at this level. Even though they are half way through their degree, you know this is day one, day two, day three really of their nursing in lots of ways (FG one, generalist).*

It was apparent from the focus group discussions that the participants had specific expectations of the students from assessment of their knowledge, clinical skills, personality, and previous nursing experience. They were aware that a major element of their role was to conduct formative as well as summative assessments of the students that would be forwarded to the university. So their initial assessment was to help clarify the baseline from
which the student’s performance on clinical placement could be assessed. Because of their obligations to the university, they needed an in-depth understanding of the curriculum and scope of practice. The participants explained that assessment of the student included assessing the appropriateness of the goals developed by the students prior to attending their placement, particularly in anticipating the need for ‘halfway feedback’ to better meet students’ individual needs. ‘Halfway feedback’, as conceptualised by the participants, is an evaluation of the students’ progress at the halfway point of the placement, allowing the facilitator to identify whether the students’ learning is being achieved. This feedback acts as a formative assessment process prior to the completion of the placement, as exemplified by the following remarks:

On day one the goals of the students are important and I actually look at them as soon as I can…I think that the halfway feedback for me is absolutely crucial. I can then see in partnership if these goals are being achieved. This is an incredibly important part of my role as a facilitator (FG one, generalist).

While assessment of the students was noted to be an important role, focus group discussions indicated that assessing the local environment was also necessary to the success of a clinical placement.

Assessing the local environment
For the participants in this study each placement was different, and they determined that a pre-placement visit to assess the local environment was important to placement success. This assessment was important for both the facilitators and students as they felt that if they were not familiar with the area, they could not successfully orientate the students. The local environmental ‘scan’ included the agency location, clinical areas, meeting relevant staff and also identifying if the agency provided a kiosk, tea, coffee facilities and public transport. Participants were unanimous in their need to undertake a pre-placement agency visit, especially if it was a new placement, to ensure local knowledge of the facility. Some explained that even though
they may have been to an agency previously, a recent visit was beneficial to
gauge the intricacies of the clinical areas, and reacquaint themselves with the
clinical staff who would be working with the students. They explained that this
process usually assisted with their acceptance by the staff on the ward when
they came to facilitate the group of students.

*I am representing the university…I am upholding the relationship for
the university (FG one, paediatric specialist)*.

Another advantage of this pre-placement assessment was that it allowed
them an opportunity to convey their role as ambassadors for the university,
as one participant aptly explained:

*I think when you go to a new agency you always have to find out
correct channels,…knowing which person to ask…often it is hard to
find out that information in a new place (FG one, generalist).*

Another important aspect of best practice clinical facilitation was assessing
the local environment was to know the policies of the health care agency that
they were visiting, and where to access such information in preparation for
advising students the source of information.

**Matching up**

Once the participants had assessed the environment and the students
they explained that they would go through a process of ‘matching up’, where
they would ensure that students were allocated to an appropriate ward area
and a suitable staff member where learning goals would be achieved. As
one participant recounted:

*I like to think that I can start matching up…depending on which ward
the student is going to…for example there may be a rehabilitation
ward where I know that there will be perhaps limited opportunities for
certain procedures (FG one, generalist).*

Other facilitators described processes that were consistent with this practice
of matching up, and described it in other ways. For example:
I look at what year level the student is, what specialty they are going to... the learning possibilities in the area...I plan my day considering the students’ personalities, finding out if any have a nursing background (FG one, generalist).

Another used the metaphor of marriage in explaining this concept:

What the wards can actually offer them in terms of learning environment and marry that up (FG two, Oncology specialist).

This approach was common amongst the participants and designed to give the students the best possible experience as exemplified by the paediatric clinical facilitator in focus group one, ‘I want them all to have the best possible prac, the best possible experience’. Another participant who had previously worked in university laboratories and tutorials described this experience as an advantage in helping understand what the students had covered. This knowledge helped with the process of marrying the theoretical components to the actual clinical experience. It was important to the facilitators to feel they had the appropriate type and depth of experience required for the placement. The mental health facilitator reiterated the special needs of students undertaking mental health placements. She saw these placements as different from other areas, wherein students displayed unique fears, and where the students were concerned with the specific skills for mental health. She approached these particular needs by identifying student concerns as being inherent to their needs, and then working towards matching the students’ needs with the potential learning opportunities available in the placement. This approach was described as a way of building their confidence and ensuring that learning outcomes were met. Several clinical facilitators described how they would check their own knowledge of the area in which the facilitation was to take place:

I research the areas if I am unsure, some wards have information booklets. (Focus Group one, generalist)

This acknowledgement by the facilitators of the checking their knowledge ensures they were familiar with the areas and therefore had the
knowledge and capability to match student needs to the experience available in those areas.

**Learning to facilitate**

*Formal and informal preparation*

For the participants in this study, the extent to which they were formally prepared was fundamental to their construct of best practice clinical facilitation. They explained their educational preparation for the role and how their knowledge had developed over time. All participants held a bachelor’s degree and were experienced registered nurses who had been given an orientation to the role of clinical facilitator, but few had formal preparation for the actual skills for facilitation. The focus group discussions revealed that most of these facilitators had started with limited knowledge and had no guidelines to follow when they commenced in the role of clinical facilitator. Some had deliberately applied for the role, while others had been approached and encouraged by other clinical facilitators who thought they had an appropriate background and demeanour for the role. Because they had limited formal educational preparation for clinical facilitation, they relied on their experiences and those of other facilitators, as the remarks of one participant illustrate:

*I have been continuously told over the years that this is a very, very important role; however, there doesn’t seem to be a great deal…there isn’t much formal education related to specific facilitating (FG one, generalist).*

While most of the participants reported that a university course for facilitation would be helpful for clinical facilitation, not all believed this to be that case. One participant with over 15 years experience as a clinical facilitator reported not being convinced of the benefit of a formal course, suggesting that her ongoing experience as an RN then as a clinical facilitator had shaped her knowledge and best practice in clinical facilitation.
[I] am not convinced that the graduate certificate has made a difference to me it may, [I] think [I] knew that some of that’s what I’d known from working with them [students] over years and years. Some of those looking at different learning styles, even though you didn’t have a formalised theory behind it. It [graduate certificate] probably will help, it probably has helped but I think a lot of that I knew it was knowledge that I already had gained even around assessing.

For the participants in the study, learning on the job was at the core of their skill base and development. While clinical facilitators are typically employed by universities participants did not see themselves as academic staff in the true sense of the word. They are foremost registered nurses who undertake the sessional role of clinical facilitator. Some participants identified that despite being appointed to the facilitator role, they had not been taught how to teach and engage with students. In some cases, other clinical facilitators had helped out and given them guidance, especially in judging the requirements of students with different needs and how to respond to these students appropriately. Others suggested that they had learnt from others and also through trial and error – learning from mistakes. One clinical facilitator explained that discussion with other facilitators had helped her deal with challenging students. Assistance from the university course convenor and clinical coordinators had also been beneficial in assisting with knowledge development. However, most wanted formal education to facilitate, and considered there was a need for formalised preparation.

I had an interview on a Thursday and started facilitating on the following Monday – no education… luckily I had been a clinical educator in a hospital in my previous role so I knew what clinical education was. I found another facilitator and we had a chat about paperwork and how to write the assessment tools and she gave me some written guidelines which I have since passed onto lots of other facilitators, some written like sentences that relate to the assessment tool of how to describe the students’ achievements, so that is how I started (FG one, generalist).
Just knowing if I was stuck I could call the clinical coordinator (FG one, generalist).

I learnt on the job – there wasn’t a lot of guidance around on how to structure your day, what your role was, it wasn’t clearly defined (FG two, generalist).

These statements highlight that the clinical facilitators sought assistance and used the resources available to them either through networking with other clinical facilitators or through the staff at the university to learn how to facilitate. They affirmed that once they had learnt they passed their knowledge onto others, however it was clear that they would have felt better prepared for the role if they had been provided with clear guidelines for practice, presumably from the university. One participant in particular said she felt “privileged to have the opportunity to work as a facilitator in nursing education” (FG one, paediatric specialist).

Maintaining knowledge

As previously mentioned facilitators’ knowledge of the role developed through their experience of engaging with students, other clinical facilitators, attendance at workshops and through the preparatory workshops offered by the university. While the participants also acknowledged they tried to keep up to date by reading and research, there was in their view limited literature on clinical facilitation to help maintain and expand their knowledge of the role.

[I] try to keep myself updated with research, but there is not a lot out there written about clinical facilitation.

All the clinical facilitators explained that they worked towards keeping up to date with the curriculum and maintaining their own knowledge of both facilitation and their areas of nursing. Many drew on their previous experience, some explaining that they were life-long learners. For example, two facilitators reported that they had completed, certificate IV in workplace training and assessment. One identified that she had undertaken a graduate certificate in clinical education and a couple of others indicated that they were
currently studying. They also felt the opportunity to network with other facilitators helped develop knowledge and skills for the role, working toward best practice.

**Networking and shared knowledge**

Many of the participants identified that networking with other facilitators was beneficial in structuring their facilitation routine with the students. The networking occurred while undertaking the role within the health care agencies and also at workshops as well as informally with colleagues. For some of the participants, their knowledge of facilitation was handed down through other more experienced clinical facilitators and clinical coordinators.

*I had coffee with a colleague socially – she told me what the job was, and I was writing down furiously, saying ‘say some more’ what, what else do you do?’ And had I not had that conversation I think I would have sunk a long time ago. And it was very, very helpful having the knowledge from people who had walked the pathway before you, is just instrumental I think in helping me get through facilitation* (FG two, generalist / midwifery).

The following quote from another illustrates the importance of networking and sharing knowledge for best practice clinical facilitation:

*I had applied for facilitation and had got the job. I knew I had my first facilitation moment coming up and the information was not forthcoming about how you structure your day, what is the expectation, so I was going in quite blind until I had this conversation with a colleague who had facilitated for some time by then. Ah yes I am indebted to her for giving me the low down* (FG two, generalist).

The participants explained that experienced clinical facilitators willingly passed their wisdom onto them, understanding that they were less experienced. Networking with experienced university staff was also identified as important and useful in learning the clinical facilitators’ role. Many of the
participants also identified that while the preparatory workshops were useful and contributed to their learning, they did not see these as formal preparation, given that they did not lead to a formal qualification. All clinical facilitators explained that through exposure to one another and sharing of experiences they had come to have a greater understanding of the clinical facilitator role.

"I think workshops helped. I remember we had debriefs after the placements as facilitators and that was very useful. I think I would be a different facilitator now than I was 4-5 years ago because of the extra learning. I find networking with other facilitators useful and supportive – I always exchange phone numbers, not always from the same university (FG two, paediatric specialist).

Networking was a major influence on helping clinical facilitators share experiences to develop the role effectively in providing best practice clinical facilitation. While the workshops were considered beneficial the participants explained that they often felt alone and by themselves while they were working in the clinical environment with the students. As one participant revealed:

"You are in no man’s land; you do not belong, you are out of the university, and yet you are representing the university, but meanwhile you don’t belong to the staff environment that you are working in, so you are this bridge between the two (FG two, general / midwifery specialist)."

Facilitating effectively

"Facilitating effectively" emerged as one of the major themes from the analysis with the three subthemes of interacting, and communicating effectively and being supported and exemplars of best teaching practice from their experiences as clinical facilitators to support how they facilitate effectively. The participants indicated that to facilitate effectively they must have highly developed communication skills, demonstrate appropriate
interactions between all staff and students, and have an understanding of the importance of role modelling. Other aspects of effective facilitation were explained as being supported by the university and having a rapport with the buddy nurses.

Interacting and communicating effectively

The participants stated unanimously that to provide a quality clinical placement for the students they had to ensure that their interactions with staff, students and patients within the health care agencies were enacted appropriately. Without effective interactions and clear communication they believed that the students' clinical placement would be jeopardised. They explained that effective communication was paramount to the students’ clinical experience being individualised, which was often negotiated between the student, university staff and agency staff. In the context of these negotiations, the clinical facilitator questioned each student individually to tailor their teaching strategies to the student’s learning needs. As the liaison between the agency and the university they constantly had to use appropriate communication with all facets of the workforce. Communication skills included effective mediation skills and the ability to resolve conflict; skills they described as having learned from experience. Appropriate communication and actions were also seen as necessary to ensure that the role was valued. As one participant outlined:

You keep the ward well informed or the hospital educator informed of what you are doing and what is happening,… like you know just saying ‘hey is it okay if I send my student to theatre’?, I have got permission. Good communication between the two parties is, I find, the more you are accepted – they remember you when you come back next time (FG two, intensive care specialist).

The participants maintained that negotiating with the staff on the ward and asking their permission to work with them and their patients helped the clinical facilitator gain the respect of the staff. Their view was that effective communication was the key to improving the clinical experiences for the
students while allowing them the opportunity to practise their clinical skills and improve their knowledge. Maintaining these skills helped in their role as advocates for the students, particularly when they developed good relationships with healthcare staff and had support from the university staff. For example, one facilitator mentioned an appropriate interaction as the introduction of students to the nurse unit manager on their arrival to the ward on the first day. Her expectation was that this would establish a pattern where the students would introduce themselves to the staff members with whom they were to work each day. In her own words:

[I] just ensure that they have been oriented well to the clinical environment, introduced to key staff within the area, like the Nurse Unit Manager and clinical nurses (FG two, Oncology specialist).

Some of the clinical facilitators identified that providing orientation and staff introductions was paramount to the students having the best possible clinical placement. Others underlined the importance of fostering good communication between the university and the clinical facility to ensure two-way communication was maintained:

I find having a good working relationship with the hospital educator is a huge advantage because they are the bridge…between the hospital and the university (FG two, mental health specialist).

Another thing that I have found works is the course convenor actually coming out, and gathering all his/her facilitators for a meeting; I found that really works well. It makes you feel really supported out there, like it makes you feel...like the university really cares about you and your clinical experience (FG two, paediatric specialist).

A couple of participants commented that while they should be visible and easily accessible to the student on the ward, the buddy RN was ultimately responsible for the patients. They reported being vigilant in ensuring that the buddy RN would not push their work onto the students and clinical facilitator to complete or disappear from the student. Another aspect
of their interaction was encouraging the buddy RN to take responsibility for supporting the students, as is illustrated below:

*We need the buddy RN to be committed and also to take some responsibility, I find if you are there in an excessive presence the buddy will give that responsibility away (FG two, mental health specialist).*

*It's about empowering and supporting the buddy RN to do that role even better, that's actually the knack of doing facilitation (Focus group two, Oncology specialist).*

All participants identified that they felt good communication and feedback is essential to best practice clinical facilitation, explaining that they would like to receive the kind of feedback that would allow them to know how they were performing in their role as clinical facilitators. The facilitators advised that while they wanted feedback this was not forthcoming. As part of the clinical facilitators’ role they undertake assessments on the students during the clinical placement, using standard assessment tools developed by academic staff. The participants highlighted that they would like to receive feedback on their assessment of the students and the documentation that they provided back to the university.

*In over eight years of facilitating I have never had any feedback on whether my assessment tools are any good or not. Not all the time I get student feedback sent to me, but I have never had feedback from the university…so I assume I am doing a good job. There could be areas that I could improve in that no one has pointed out (FG one, generalist).*

*I would agree that in eleven years I have not heard from the TAFE or both unis I work with. I have never had feedback (FG one, generalist).*

*I guess I take it that I am doing a good job in that I have been rung by other universities and TAFEs to work for them because you have been recommended to us and that you might work for them. I have taken that as I must be doing okay (FG one, generalist).*
The clinical facilitators felt that knowledge of how they were progressing was instrumental for them to know what they needed in keeping up-to-date and further developing their facilitation skills. Some said they presumed that feedback was positive because of their continuing employment in the role of clinical facilitation. Without feedback the facilitators may not be undertaking education appropriate to their needs, which presented a dilemma as to how they could improve if improvement was required. Feedback was seen as an important yet greatly lacking communication strategy, equally as important in the pursuit of best practice clinical facilitation as being supported. This lack of feedback was considered a barrier to providing best practice in clinical facilitation.

**Being supported**

Support was identified by the participants as being essential for best practice clinical facilitation, particularly when they needed to discuss student issues with someone. One of the participants suggested that new facilitators need support during their early days of clinical facilitation to ensure that the facilitator was maintaining a standard of facilitation expected by the university:

*I think the new facilitators certainly need much more support and I tend to give that to the new ones in mental health during our networking sessions, because some of them are really quite lost. I think just supporting them will help to overcome inconsistency so they are aware of what the expectations are (FG two mental health specialist).*

The participants were unequivocal in explaining their need for clarification of the clinical facilitator role from the university when commencing in the position. Then in the clinical setting they needed to explain their role to the ward staff, including the registered nurse who would be buddied with the students. Support for their role and their student was therefore dependent on all staff gaining a clear understanding of their role and responsibilities. They also needed to clarify the role for students, to help
them gain a clear expectation of the placement, as the following excerpt exemplifies:

*I have found through experience and often in the orientation process it is best to apply clarification of what our role is to the students… and then they have a clear expectation of what our role is... and similarly that also prevents problems I have experienced with RNs that they buddy up with. Sometimes they are not clear about our role...I have actually had students’ minds poisoned big time by destructive RNs. I am not being paranoid here, but occasionally you’ll get an RN who is a little bit resentful or resistant to being in the role … they can then be quite destructive. An example would be: how come your clinical facilitator is not on the ward all the time with you? And that can sometimes conflict with the buddying role and I think there is some confusion there with what our role is (FG two, mental health specialist).*

Clearly, support and good communication were integral to best practice. Where support was lacking clinical facilitators struggled to understand their role. As previously mentioned one of the participants indicated that the role of the clinical facilitator was often quite lonely as they are visitors to the health care agencies. This loneliness is considered a barrier to the effectiveness of the clinical facilitator in that the isolation makes the clinical facilitator feel alienated, as they are usually employed by the university and not the healthcare agency. Other focus group participants agreed that they also felt alone while with the students in some health care agencies.

*It is a very lonely position particularly in the private sector and if there is ever a complaint about us it is very difficult to have any right of reply (Focus group one, generalist).*

*Until you become well known, often once you are well known you are more accepted and you are more involved with the team (Focus group two, paediatric specialist).*
Another participant suggested that while the role was relatively autonomous, clinical facilitators wanted support and guidance from the university staff, in particular, the clinical coordinators. Participants considered that role clarity developed as a result of experience and support from university staff and health care professionals. Visits from the course convenor also provided them with a person to consult with in relation to students and their learning requirements, which brought other facilitators together, as one participant remarked:

*It makes you feel really supported out there, like it makes you feel like the university really cares about you and your clinical experience.*

They also reported feeling supported when there was liaison with clinical coordinators, professional practice coordinators and other members of the academic staff from whom they could gain educational guidance and knowledge to work towards best practice clinical facilitation. Although the facilitators identified that they felt supported through liaison with the professional practice coordinators and other members of the academic staff the foregoing section highlighted barriers to facilitation. The clinical facilitator comments highlight the barriers to clinical facilitation as professional isolation, lack of clear policies and guidelines, balancing professional loyalties and a lack of educational foundations and performance feedback.

**Exemplars of best teaching practice: The uniqueness of clinical teaching**

All participants considered role modelling an essential part of the clinical facilitators’ role and a measure of best practice. They described role modelling as being professional, flexible, supportive, an advocate for the student and patients, not biased, and having a high level of clinical skills with appropriate practice and interaction with others, while meeting the learning needs of the students. Members of the group considered that they should be committed to the student and display appropriate practice, with one also suggesting that the buddy RN needs a similar commitment.
I think it is important in letting them know (the RN Buddy) exactly the scope of practice, what experiences the students have, so I always tell them when I am taking them [the students] to the ward, this is the first time they have been in an acute hospital setting, and I put up their scope of practice. I stick that up on each ward (FG one, generalist).

Some of the participants commented they had encountered difficulties when they first commenced facilitation. One identified that the role was challenging particularly for those who have worked on a ward and then progress into facilitation on the same ward, because ‘you needed a balance between the two roles when you have worked as a registered nurse on the ward’.

I found facilitating a little bit difficult to start with at first because you are kind of learning on the job and you do make mistakes, and you rectify them, and I think that that is also a problem. We haven’t got consistency amongst all the facilitators in the approach and some of the less experienced clinical facilitators can sometimes have a negative influence on what we are trying to do (FG two, mental health specialist).

The challenge originally was more about changing from being a clinical person to a student person from being a person that the ward staff would call to come and check a DD…because I first facilitated in an area where I had been working and was well known…that was very difficult. The initial reports from students of my facilitation were quite negative…they felt that I was affiliated more with the unit [the ward] than them [the students]. So I learnt from that…I think those first three or four times facilitating were very challenging and I then identified that I would probably be better if I go to a different ward area from the actual unit that I worked in and I think that it does make a difference (FG two, paediatric specialist).
Some of the comments from the focus group revolved around the parallels of doing best practice as a nurse and doing best practice as clinical facilitators. One of the participants questioned whether best practice was incorporated into the facilitator role:

If it [best nursing practice] is part of our role, would there be room for adding best practice into the facilitator role at some level? (FG one, generalist)

Yes I think so, yeah it should be the same as the RN on the ward and the facilitator has the same responsibility looking at their best practice role. It is a responsibility and you need to develop it to the best of your ability for both yourself and the student (FG one, mental health specialist).

Another participant in the group suggested that while a registered nurse could be a great clinician working in a best practice model, they may not have the skills, knowledge, attitude and interest to undertake the role of that of a clinical facilitator. In this, the participants were unanimous:

Not every RN out there can be a clinical facilitator (FG one, generalist).

You are responsible for training somebody to do another clinical role (FG one, mental health specialist).

Some nurses are born teachers and they just explain it so well (FG one, mental health specialist).

These remarks highlight that clinical facilitation for these participants was a specialty practice as is the case for other areas of nursing. Moreover, they recognised skills and knowledge in other registered nurses in a mentoring role to recruit suitable staff into the clinical facilitator role:

I also feel part of my role, as encouraging people who I see who are really good with students to be a facilitator…and I often say to people you know you’re so good with working with students if you are
interested in facilitating this is the number to contact, because I know they have got it (FG one, generalist).

Some clinical facilitators acknowledged that they had changed their practice through trial and error and considered how the changes have influenced future practice. When prompted by the researcher to explain what had influenced them to change practice they provided accounts of their experiences:

I’d like to share. I have just finished a placement I had an ADHD student, the first time in 8 years, for the first week even the NUM and the ward staff just thought he was fabulous because his enthusiasm and everything was wonderful and his personality. He was in the oncology day care unit no structure accessing lines, portacaths but then as it unfolded, sort of on the Wednesday of the first week, hang on a minute, there was very inappropriate loud talking in front of oncology kids and mothers, you know just socially, this social ineptness. So I had four weeks with him and ah look I just grew I worked with him a lot. In the end he was on medications. I just took him away and said how can I help you, and we sort of worked out this wasn’t the area for him and he did need a structured ward. I worked very closely with the NUM and the staff.

It is the first time I just think I grew so much as a facilitator, I think that I could handle that situation now again um, we broke things down for him. Just simple sterile techniques, communication, I gave him the queues of bring the volume of your voice down; I’d give him a wink or a something so that he knew that he was too loud. We went above and beyond really to assist him. We just needed to bring it back to the basics, the uni[versity] are on board now with a whole lot of strategies. I had never encountered a situation like this before; this was like having a six year old in this intense oncology ward. It was amazing and I think I would pick it up and be able to deal with a situation like that now (FG one, Paediatric specialist).
When asked how her practice has changed, the clinical facilitator recounting the story above advised that she tries to catch issues early. Getting to know and understand the students was explained as crucial to meet the ultimate goal of best patient care. Another participant commented:

*Here is my stand out story – when I was fairly new to facilitating I found out on the Friday of the first week of a two week prac, that my middle aged male student could not read or write. Because he was middle aged he was very adept at covering all this up. He’d gone to TAFE before he went to uni and did their literacy course which takes you to grade 5 level which is not university level reading and writing. I had quite a few very young, very scared students that I’d focused on and I checked with him several times a shift, everyone said he was great. On the Friday I actually worked with him and to do medications I had to stand back and let them find the medications – he knew it began with P but he couldn’t tell if it was penicillin, paracetamol or anything else beginning with P. Which to me really showed the value of the role of the facilitator because I could stand back, but his buddy RNs would always do the saviour rescuing behaviour, there it is and he would always, Oh I can’t see it for looking, or I left my glasses in my bag. All the behaviours he had used for years, to compensate for not being able to read or write. Even counting – he read the pulse at the end of the bed and took the patients pulse, and I just held onto the other wrist and he told me it was two points different from what had been written there but it was 20 points different from what I’d got. So I said just try (FG one, generalist).*

When prompted to explain how she had used this incident the clinical facilitator explained that it had reinforced her behaviour of standing back, to watch and assess initially, and to not make assumptions about students. This view was based on her understanding that they may present well and capable, but often the confident one is the one with the biggest deficits. The facilitator explained a strategy she now uses to assess the students:
One strategy that I have, is, on the first day of prac I get the students to read to me from the progress notes because I tell them that one of the skills they need to learn is to read Doctors’ writing and I say let’s go through this together and see if you can interpret the Doctor’s writing and they read aloud from the Doctor’s notes (FG one, generalist).

Further discussion within the focus group highlighted that the clinical facilitator had not consciously realised that the incident where the student had difficulty reading medications had influenced the way in which she now conducts her assessment and facilitation of student groups. She commented that while she used the strategy of having the students read aloud she had never recognised that she was assessing the students’ literacy skills until now. The knowledge that was developed from this incident highlights that the clinical facilitators’ role continues to develop over time, with experienced clinical facilitators underlining the fact that they refined their teaching skills as they went along.

Another account outlined the value of specific experiences to best practice clinical facilitation. One facilitator explained that a nurse educator had taught her that a student who refuses to undertake a task may have had a bad experience and those students should not be pigeon holed as a problem student. The example illustrated the need to be cautious rather than making assumptions about students.

An educator at a hospital a few years back gave me a different way of looking at things; she had a student and had said to the student they had a catheter to put in. The student said ‘I have already done one of them’. Instead of saying or thinking I have a difficult student she actually said so you are never going to put another catheter in again. The student said not if I can get away with it. So the educator thought okay something has happened here and she investigated further and found that the students’ first catheterisation experience was a 150 kilo lady, who was an exceptionally difficult catheterisation where the student had been unsuccessful and that the student was scarred of
doing this task again due to the previous experience (FG one, generalist).

The facilitator explained that because of this discussion with the nurse educator she has changed her interaction with students and now questions students about their experiences to understand their learning needs. This strategy also helps ensure that students see her as approachable.

*It basically scared the student so I thought…with this student and deeper thinking and questioning [I] found exactly why the student was terrified of putting a catheter in* (FG one, generalist).

Another participant gave a suggestion about the incident she discussed.

*This also highlights that there are still staff out there that do that, who will pass off to students and facilitators the jobs they do not want to do and again, that is when we are the advocate to say sorry that is not going to work* (FG one, generalist).

The interaction between the clinical facilitators illustrates that they were able to reflect on the issue at hand and provide insight and suggestions to each other relating to the issues of concern.

**Summary – What constitutes best practice clinical facilitation**

At the conclusion of the participants’ reflecting on memorable incidents that had enhanced and changed their practice, they were each asked to consider and summarise into the top six points what they thought constituted best practice in clinical facilitation. While there were some areas of overlap the following is a composite of their comments. First, it was important for them to assess the student needs and clinical environment. Second, interpersonal skills were important for appropriate communication and responses. Third, professional role modelling of clinical and academic knowledge was beneficial, to liaise between student, RNs, agency and university. Fourth, maintaining knowledge of current research, nursing policies and procedures of facilitation assisted to provide students with
direction. Fifth, maintaining knowledge of teaching and learning processes – knowledge of curriculum, goals and scope of practice. Finally, it was suggested that all clinical facilitators need to build on knowledge through experience. A number of barriers to best practice were identified through the interpretation of participants’ comments during the focus groups, and these are outlined following the sections below on concept mapping and interview analysis.

**Concept mapping**

As noted in the introduction to this chapter, focus group participants were requested to develop a concept map outlining clinical facilitation and what they thought constituted best practice. The concept maps were developed by the clinical facilitators by reflecting on their practice and creating notes and interlinking diagrams. Concept maps are used to generate ideas and produce visual maps of key ideas of the clinical facilitators (Andrew & Halcomb, 2009). The groups were advised that they could discuss their ideas although they all developed different shaped diagrams with some core ideas identified, including assessing students, experience as a facilitator, negotiation and facilitator education. Appendix D presents the concepts maps from focus group two. Comments from the eleven participants who developed concept maps indicated that they thought this research approach was fascinating and their interest in the process was evident in their diagrams.

A deliberate, iterative approach was taken to analyse the concept maps. The content was categorised in terms of facilitation processes that had been identified in the focus group discussions and grouped into skills and knowledge that was undertaken to undertake the process of clinical facilitation. In the analysis of the concept maps it was evident that the facilitators undertook a cyclical process, where they prepared (planning and preparation) for the placement at the time they received the paperwork from the university which included the student list, assessment tools, course outlines, formative paperwork and the agency for the placement. The concept
maps illustrated that on commencement of the placement the students were assessed, and the goals and personalities of the student group were considered, including assessing personal needs and the students' knowledge. Within these assessments there were formative tasks and questioning of students and assessing how the student was progressing through their placement, concluding with a summative assessment at the completion of the clinical placement.

The third phase of the process was the actual facilitating, creating strategies to give the best experience possible and empowering the students. This third phase allowed them to tailor the strategies to student needs, ensuring that the students remained within their scope of practice. The concept maps also identified that the process of facilitating required the clinical facilitator to be responsive to people, situations in the ward and the buddy RN. There was a consensus around the importance of building relationships and communicating in a timely and appropriate manner with students and others. Building relationships included being accessible in the health care agencies, reporting progress and liaising with the university. Information from the concept maps illustrated the necessity of evaluating and re-evaluating. Evaluative data were used to make changes, particularly in the approach to student assessment and how the clinical facilitators undertake the process of facilitation and changes that they are required to make on a daily basis.

The concept maps illustrated the cyclical processes that facilitators reported in the focus group discussions. Concept mapping allowed the clinical facilitators to link their ideas together. The way they presented and explained the concept maps indicated that the process was reflexive. They constantly reflected back on their own actions and practice to evaluate, develop and build knowledge of clinical facilitation while undertaking systematic assessment for the students. Analysis of the concept maps in relation to the thematic analysis was used to construct a model of best practice in clinical facilitation (see Figure 4.1).
Concurrent with development of the model, the final phase of the study involved individual interviews to try to ensure completeness of the data. The following section of the findings analyses the data collected from the individual interviews where, like the focus groups, the systematic constant comparative method was used to move back and forth between the individual responses a number of times. This phase was designed to identify the extent to which the interview analysis corresponded with existing themes, and to identify any new themes. Themes identified from the interview analysis included: learning to facilitate, networking, facilitating effectively, interacting and communicating effectively and being supported which will be outlined further in the following section.

**Interview analysis**

Six experienced clinical facilitators who had participated in one or the other of the focus groups were interviewed; five females and one male. Data were analysed through several iterations, moving back and forth between the individual interview responses, so that interpretations could be checked and cross checked with the original transcripts. While responses from the focus groups were analysed inductively, as suggested by Braun and Clarke (2006) the individual interviews followed both an inductive and deductive approach. An inductive approach or ‘bottom up approach’ is where the data is not coded into a pre-existing coding frame whereas a deductive approach or ‘top down approach’ analyses using coded data (Braun & Clarke, 2006). A first level of analysis consisted of reading the transcripts to identify any new themes. As no new themes emerged from the data a deductive approach was taken which involved analysing the themes previously generated to see whether previous themes were reinforced or modified in any way from the interview data. Although no new themes emerged, those interviewed placed greater emphasis on effective interaction, networking, being supported, learning to be a facilitator, and the value of experience. Each of the interviewees discussed at length how they had learned to facilitate from experiences with
students, with their initial experiences as registered nurses shaping their practice in the facilitation role.

Learning to facilitate

The interviewees reported and expanded on the sources of learning to facilitate, as they had described in the focus groups. One indicated that in the early days of clinical facilitation ward staff did not value the clinical facilitation role, which impacted on her ability to learn how to facilitate.

*I think they don't value the role…a lot of people see you… that you are just swanning around and not doing a whole lot…and it's you know an easy job (paediatric specialist).*

While she reiterated that some people still think the job is easy most are now coming to realise that the role is important and of value.

*Their attitude to us has improved, so they are much more welcoming now, - because most of the people there are university trained now…you develop a rapport by working in the same place repetitively…people get to know that you are experienced (paediatric specialist).*

One of the generalist nurses indicated that ‘you have to want to facilitate, you need to be visible on the floor and clinically involved with the students’. These skills include being able to collaborate with the students and facilities effectively. Another reiterated that she had been a student mentor before taking on the role as a clinical facilitator on the wards because she was passionate about education. She indicated that she was self-taught because education was her passion.

*I think the learning on the job has been the most important part because there hasn’t really been any formal education on how to do it…[I] don’t know that the certificate IV really helped me in the clinical facilitation role in the hospital…the first workshop the university
conducted helped although the first of those [I] went to [I] had been doing the role already for a year.

This participant indicated that the workshop affirmed that she had been doing the right thing in the clinical facilitator role. The mental health specialist indicated that the supervisor guide clearly set out expectations for facilitators and students. While this facilitator had completed a Bachelor of Nursing he did not have any formal education in clinical teaching and did not consider this a hindrance to facilitating students in the clinical setting, he thought that experience as a nurse and experience as a clinical facilitator important. Another clinical facilitator indicated that she had undertaken a clinical teaching elective, which was seen as valuable to her role. Others discussed personal approaches that helped them consolidate the role. Another participant indicated that she facilitated intuitively for many years and that having completed her graduate certificate in education backed up the theories underpinning what she had been practising. She also explained that having completed the graduate certificate she now stopped to think whether there was another way to tackle an issue; whereas previously she had not changed her strategies.

Some who had previously worked in the buddy nurse role also indicated that their previous experience as a registered nurse mentoring and working with students had assisted them to prepare for the clinical facilitator role. Experience was a major theme identified by all the participants, including experience as a registered nurse or experience as nurse educators. Many of the clinical facilitators indicated that they had also worked with students in the role of buddy nurses. One participant indicated that clinical facilitation was practical; reporting that having been given the opportunity to tutor students on campus had enhanced his ability to facilitate.

…knowing the whole range of students’ activities and their capabilities…so that [I] can understand and support the ones that need a bit more than others (Mental Health specialist).

The opportunity to tutor had consolidated the clinical facilitators’ understanding of the courses that the students studied on campus and gave
them an understanding of expectations and requirements of students while on placement. All the participants indicated that while there were expectations placed on the students, the students themselves had expectations of the placements and that the their role as clinical facilitators meant that they were student centred in their interactions. The participant indicated that tutoring allowed clinical facilitators the opportunity to tailor their facilitation and students' learning to their needs.

**Networking**

The facilitators indicated that networking with other clinical facilitators had been another invaluable way that they had learnt the role and now they imparted their knowledge to new facilitators and those with less experience. The participants reported that not only did they network with other people undertaking similar jobs, they networked with other people doing different jobs, clinicians, buddy nurses and managers some who they liked some who they didn't. The participants indicated that as part of the experiential background that informed their facilitation they overcame the difficulties of interacting with some staff because of their total commitment to networking.

Networking with other clinical facilitators at health care agencies was seen as an opportunity to liaise with each other, and provided the ability to share common ideas for keeping them student centred. Other issues raised during the interviews included mentoring and role modelling where the emphasis was on setting an example of expectations for the students and agency staff. Interviewees indicated that they had watched and learnt from the experiences of their colleagues and that they themselves were now able to impart their experiences and knowledge onto others.

One participant indicated that she had been a student mentor during hospital training prior to the transfer of students to university and she had learnt her clinical facilitation skills through this to start.

*I always mentored student nurses in the old hospital system...and then when they came into the university I was mentoring them in the*
wards…I noted that there were facilitators sort of floating with them (paediatric specialist).

As reported in the focus groups, the first workshop on clinical facilitation conducted by the university was seen as extremely beneficial, but networking with other clinical facilitators was considered very helpful in learning the facilitator role and keeping up to date with information. The combination of resources such as the supervisor guide, clinical practicum policy and other university polices provided by the university were helpful, as was networking with academic staff and other facilitators.

**Facilitating effectively**

One participant indicated that her diversity of experiences had assisted to shape her as a clinical facilitator, but she declared that she was not a master of anything in particular. The combination of experiences assisted her to understand the students. Another participant identified that while part of her role as a facilitator has been to support students. She actually identified that sometimes she has become the students’ confidant particularly when as a clinical facilitator she identifies that a student is not managing.

*There will be students that are upset…and they’ll cry, quite often there’s a lot of other stuff going on for them…they’ll fall apart and tell you what is going on in their lives (paediatric specialist).*

While this clinical facilitator believed her role was not to be the students’ social support or social worker she considered that knowing some of the students’ issues were helpful as this gave the facilitator some background on the students. The participant outlined that when she was giving feedback to students who were not managing she found that the student often did not believe her.

*Some students feel like you’re biased or that it’s all about everyone else not them (paediatric specialist).*
Interacting and communicating effectively

One of the interview comments was about letting the student know that they were not there to fail them when their performance was not at an expected standard, but instead to support their learning and guide them through the processes to achieve a positive outcome. Although failing students did happen and clinical facilitators found the situation difficult, they took their responsibility seriously. They also reinforced the notion that best practice in the role as a clinical facilitator included liaising carefully with university staff and maintaining two way communications.

Making sure that they’re aware of what is going on out there…most convenors value clinical as part of the subject that they are convening…part of university life and are keen to hear …I think I’ve developed that as well (paediatric specialist).

Being supported

One facilitator indicated during the interview that in her early days of facilitation at least 10 years earlier that there was little contact from the convenors… “It was like we were out there on a little island and no one really cared about you…now I feel it is very interactive and we have a lot of contact”. She held the view that the university is now more committed to the facilitators’ role although at times the facilitator may still be left on their own.

One of the participants acknowledged that while she had been employed for many years in the public health system she reported that now that she worked for the university directly clinical facilitating they were now free from all constraints of the public sector. While the facilitator indicated she understood both positive and negative aspects of being employed in the public sector this helps…negotiate with staff themselves. One participant indicated that a good relationship with the educator of the health care agency and having the ability to negotiate for students as their advocate was important to providing a positive clinical placement:
I understand positive and negative and what that leads me to…that I am able to negotiate up and down with students and staff (Mental Health specialist).

This indicates that facilitators see themselves as a mediator with the student, buddy and the university, in the middle accepting and embracing the role of intermediary. The clinical facilitator pulls everything together ensuring that the students receive a well-rounded placement which is student focused.

Another participant indicated that things have changed over the years. Her own education influenced how she considered education and, in turn, clinical facilitation of the students that she worked with.

Well I was hospital trained and it was normal for junior nurses to be taught by a senior nurse that was important, not everybody sees it that way (Generalist nurse).

For this clinical facilitator the expectation from the way that she was taught is that senior nurses assist to teach junior nurses. One of the other participants indicated that as a student themselves they were self-motivated and a life-long learner and had an understanding of the students’ expectations and the difficulties that they encountered. Another participant identified that while she was happy to support ward staff her primary role was student focused and outlined that being student focused had evolved for her over time.

At the conclusion of each interview the participants were asked to summarise what they considered as best practice. They reiterated the importance of excellent communication and interaction with health agency staff, students and also the university staff. Many identified that their acquired knowledge from their experience as both a registered nurse and as a clinical facilitator, some of which was gained through trial and error was how they developed best practice. Another participant identified that understanding the students’ scope of practice and what the students undertook in class ensured that they as facilitators could tailor the students’ clinical practice to their learning.
The following diagram was developed in view of all the data from the concept maps, focus groups and individual interviews. The four phases circling the central theme of best practice indicate the processes required in clinical facilitation. Through preparation prior to a placement with the required resources of student names and planning for the year level allocated the facilitators’ have the ability to orientate themselves and the students to the placement. The student is assessed many times during the placement first to match the student to the environment, ensuring that their goals are realistic and match the ward. For the clinical facilitator there is the process of being a role model to the student and as well as networking with other facilitators and in particular agency staff. As part of the facilitation process the facilitators require support from the university and the health care agency to provide the best possible experience for the students. The clinical facilitators are expected to provide evaluation of the students through a formative and summative process. This process is dependent on the clinical facilitators’ interaction with others and their experience and knowledge of the clinical facilitation role.
Summary

Through analysis of the data from the focus groups, concept maps and interviews the emergence of three themes with subsequent sub themes were identified. The participants clearly indicated that their main sources of knowledge for the role were experiential and networking with other clinical facilitators and through this they had developed their practice in clinical facilitation. Through their reflection on practice, the clinical facilitators highlighted that the clinical facilitator role was an ever evolving role which required the person to have excellent communication and interaction skills to deal with both the students and staff in health care settings and the university. They had no problem reflecting on their experiences, and this
underlines the fact that reflection was considered part of their normal role. A best practice clinical facilitating model with four phases was developed as a culmination of analysing the three forms of data collected as illustrated in Figure 4.1.

The next chapter provides a discussion about the significance of these findings in relation to the research questions, conceptual framework and the existing literature. The discussion chapter also includes the conclusions and recommendations of the study in relation to the impact of these findings on future education, practice and research.
CHAPTER 5: DISCUSSION AND CONCLUSIONS

Introduction

The purpose of this research was to explore what constituted best practice in clinical facilitation of undergraduate nursing students from the perspectives of those who undertake the role in health care agencies. This chapter highlights the implications of the findings and how they can be used in the future to improve learning for students and for clinical facilitators. The findings also have the potential to lead to changes in the way the role of the clinical facilitator is managed by universities and clinical facilities. Issues are discussed in relation to the research questions and the conceptual framework of the study. The chapter concludes with some recommendations for extending this line of research to provide a more comprehensive base of evidence for both education and practice.

What constitutes best practice in clinical facilitation?

As reported in Chapter 1, generally speaking the term *best practice* is used in nursing to reflect the goal of maintaining the highest quality clinical placement experience. Best practice in the context of clinical facilitation by the study participants was underscored by a high level of knowledge about clinical practice as well as effective learning and teaching strategies, which assisted students to realise their learning goals. Through reflection on their practice in the role of clinical facilitation the participants conveyed what they considered as aspects of best practice in clinical facilitation. Their role is crucial to student learning, particularly given current financial constraints on education which have meant that nursing curricula have been forced to reduce the amount and breadth of clinical placements (Girot & Albarran, 2012). This situation means that each clinical experience tends to compress a substantial amount of learning to students’ rather brief exposure to some clinical areas. It is therefore imperative to maximise opportunities for learning from every clinical experience, making the role of clinical facilitators even
more important than in the past. As indicated in the study findings, there were
a number of elements that, according to participants, contributed to best
practice. These elements all revolved around student learning. Their close
engagement with students and other staff, clinical knowledge, effective
communication skills as well as personal and professional commitment were
clearly perceived as the most important aspects of their clinical facilitator role.

An important dimension of best practice clinical facilitation was the
extensive preparation clinical facilitators undertook for their role, with all
participants acknowledging that they prepared for a placement from the
outset of receiving their placement information. While there is a considerable
amount of planning by university staff to arrange a clinical placement there is
also substantial planning required from the clinical facilitator to maintain
relationships with both students and health care personnel. Planning for a
‘best possible placement’ began once the student names had been allocated,
at which time they contacted the health care agency educator and arranged a
site visit as required, particularly for facilitators who had not previously
facilitated at an agency. Site visits allowed the clinical facilitators to acquaint
themselves with the environment and ensure they could match the students
appropriately to the clinical areas and the buddy registered nurses.
Participants revealed that assessing the local environment was important, as
every health care agency could be quite different. Their view was that if a
clinical placement was carefully planned in a systematic and predictable
manner it is easier to develop positive relationships, which create gains for all
involved. Reflecting on the clinical facilitators comments I concluded that
these clinical facilitators were public relations officers for the university in that
they negotiated closely with the agency educators and were the support for
the students.

Best practice clinical facilitation relies upon carefully assessing and
supporting each student as an individual while they undertake the clinical
placement. Once the students were assessed by the facilitator the student
could then be matched to the required learning opportunities in the ward
areas. By tailoring their approach to the students they were able to determine
which students required differential levels of support and assistance. This
strategy maintained student focused placements and also helped them to balance their time with each student to ensure that all students received appropriate opportunities while on their clinical placement.

The facilitators’ role in student assessment was fundamental to best practice clinical facilitation. The importance they placed on assessment was remarkable, particularly when some commented that they had had limited formal education, particularly in the strategies and processes involved in learning and teaching. It was heartening to learn that the workshops in the use of clinical assessment tools provided by the School of Nursing and Midwifery were effective, in that all clinical facilitators identified they had highly developed skills for formative and summative assessment. They reported using this knowledge extensively in practice, and remained vigilant to ensure congruence between students’ understanding of learning goals and the curriculum requirements as outlined by the school. The responsibility of assessing student learning in the practice setting has been underlined in previous research, by Price (2012) who identifies it as one of the most complex and sophisticated forms of evaluation that registered nurses are tasked to undertake. Study participants expressed a view that they were responsible for ensuring the student was safe and knowledgeable to provide quality care for patients. Their comments corroborate Price’s (2012) view that assessment of students in health care settings requires careful consideration of managing risks to patient safety while meeting targets and service standards. It was interesting to note that the clinical facilitators did not just take a cavalier attitude to these responsibilities, but made an effort to consider the characteristics and personalities of the students in shaping their learning experiences. This considered approach was one of the strategies they used to tailor each student’s experience to their particular learning needs. High quality clinical assessment of student nurses is crucial to the future of the nursing profession in ensuring that students have met the requisite standards of practice and competence required to function as a registered nurse (Helminen, Tossavainen, & Turunen, 2014). The clinical facilitators readily accepted this responsibility for student outcomes and tried to provide the best placement for them by being focused on both the
processes of students’ learning and learning outcomes. Some mentioned how difficult the challenge was for new facilitators and that networking had assisted them learn the processes and strategies for clinical facilitation. This networking would suggest that there is a need for new facilitators to be mentored by more experienced clinical facilitators.

**Clinical experience and knowledge**

The clinical facilitators acknowledged that they had learned the importance of being well prepared for the placements from their own experience of clinical facilitation and from being informally mentored by other experienced facilitators. In the context of assisting the students they had become life-long learners themselves, which, in turn, was role modeled to the students. Having been mentored by others they tended to willingly accept responsibility for mentoring other junior facilitators, which also assisted them in bridging the ‘theory-practice gap’, as was discussed in chapter one. The importance of clinical knowledge is illustrated in the diagrammatic representation in Chapter 4 (Fig. 4.1) developed from the thematic analysis of the focus groups, concept maps and individual interviews. The diagram incorporates the experience and the knowledge of the clinical facilitator as both an educator and registered nurse. These combined areas of proficiency provide an educationally sound learning environment where the focus of the placement is on students’ clinical learning. The diagram illustrates the interactions between facilitators’ knowledge and the actions involved in student assessment, planning and evaluation. Each of these aspects must be addressed competently to fulfill the obligations of the clinical facilitators’ role. Interaction between all elements is symbolic of the need for clarity and integration of both clinical and educational knowledge and communication among those who provide it. Nursing practice is now expected to be evidence-based and highly professionalised in that contrary to the past; they have control over education, regulation, and, to some extent, practice.
Effective communication and interactions

Effective communication was regarded as vital to best practice clinical facilitation. Communication was linked to several skills including interpersonal skills, interactions between themselves and health care agency staff and role modelling. The ability of the clinical facilitators to balance the expectations of the university and the clinical organisations was a highly developed skill. All study participants reported creative and appropriate communication strategies to meet the needs of the university and healthcare organisations for each clinical placement. Their comments indicated that they felt that the school’s professional practice coordinator was accessible for advice, even when there were personal matters to discuss, such as concerns about students’ medical conditions. This relationship was based on trust and mutual respect. During facilitation they also acted as advocates for the students, demonstrating professionalism in the way they practised in both the academic and clinical settings. The facilitators’ interpersonal skills in generating trust and respect in the context of their role were exemplary, perhaps out of necessity, and they reiterated the importance of their commitment to both communicating well and being good role models.

The interactions and the overall relationships between the clinical facilitators and the agency staff were noted to be extremely important to the success of a clinical placement. Grealish, Henderson, Quero, Phillips, and Surawski (2014) identified that facilitation activities appeared to have an effect on organisational learning culture and, while their study focused on aged care facilities, the results suggest that good communication and engagement with the organisation improves outcomes. The facilitators in the current study explained that they worked and negotiated with the buddy nurses in particular to ensure the students’ learning experiences met the students’ needs. Interestingly, some of the clinical facilitators in the current study explained that when they first commenced facilitating the buddy nurses were not helpful, withholding information from the students and undertaking tasks before the students had the opportunity to complete them. This type of reaction has been reported in previous research, but over time this situation has improved (Brammer, 2008), with the interaction between the two parties
becoming more cohesive in Australian health care (Hegney, Eley, & Francis, 2012). In the current study, improvement in these relationships did not occur by chance, as the facilitators took deliberate steps to overcome the initial resistance of the buddy nurses to their presence in the ward by spending time negotiating with the buddies, explaining expectations of working with students and the students’ scope of practice. Their approach to resolving issues enhanced the experience of the placement for both the student and the buddy RN. This ability for conflict resolution in the practice setting may be a sign of professional maturity after several decades of lamenting the theory-practice gap experienced by both clinicians and educators, which has been a barrier to collegial relationships.

The theory-practice gap in undergraduate nursing education has been the subject of many professional debates and commentaries as well research as highlighted in chapter 2. Eggertson’s (2013) commentary in the context of a Think Tank on Canadian undergraduate nurses’ education contends that senior Canadian nurses believe there continues to be a gap between clinical practice and education. Eggertson (2013) also argued that clinical staff should be engaging in the teaching of students, linking this suggestion to the view that not enough highly competent nurses were being used to provide direct education to students in the clinical areas. These clinical staff could provide evidence-informed knowledge for practice irrespective of their formal educational preparation for evidence-based practice.

Brammer (2006) was one of the first Australian researchers to address specific tensions between the clinical facilitators who represent educators, and the buddy nurses who represent practitioners. She found that collegiality between the two parties could be resolved through student centred learning environments where the students were supported through role modelling by the buddy RNs. Her findings that emphasised the importance of role modelling, confirmed the earlier findings of Lee, Cholowski, and Williams (2002) and Mogan and Knox (1987) who found that students identified role modelling as the highest rated characteristic of good clinical facilitators. Lee et al. (2002) also found that even when comparing students’ and facilitators’ rating of the characteristics of good facilitation, students also ranked role
modelling higher than facilitators. Improving interactions between the two parties (educators and practitioners) has had a major influence on students’ clinical experiences in providing a positive perspective on professional relationships. Their interactions allow the clinical facilitator to ensure that the theory-practice gaps are minimised, especially when the clinical facilitator discusses with the buddy RN her/his expectations, the students’ scope of practice and how this information can enrich student placements. The opportunity to develop these often diverse relationships is also an effective means of promoting good relationships between the university and the health care agencies. In effect, the clinical facilitators are the ambassadors for the university and, in this respect; they also fulfil a public relations role.

**Personal and professional characteristics**

The facilitators felt that they had a range of unique skills and motivation for the role. A couple of the eleven facilitators indicated that to be a clinical facilitator one needed to have a passion for teaching and want to work with students. As mentioned above, they believed it was important to be student-centred, which is congruent with previous research (Hickey 2010). They also identified leadership, having excellent interpersonal skills, having awareness of situations in which students were involved, being the students’ advocate and, as previously mentioned, role modelling. It was interesting that their focus on interpersonal skills was consistent with those identified in Benor and Leviyof’s (1997) and Knox and Mogan’s (1985) studies of the student perceptions of the effective clinical teacher. Another attribute of the role which some of the facilitators highlighted was their ability to be adaptable to the changing circumstances of the clinical placement. This adaptability would be considered as having skills in problem solving with an ability to think on one’s feet. Being able to think quickly and critically to adapt to various situations is a skill that is required of all registered nurses, and one that tends to come from experience.

Critical thinking and decision-making in the clinical context clearly requires cognitive skills that would help in identifying placement issues for
efficient and effective care. Therefore, the clinical facilitator needs to be dynamic and ‘in the moment’. This type of timely thinking helps address situational changes, which is commonly described as ‘situational awareness’ (Stubbings, Chaboyer, & McMurray, 2012). Although participants did not describe their actions in these terms it was evident in the clinical facilitators’ explanations of the differences across various placements and situations that they were focused on adapting their teaching to the situation. They reported that adapting to the situation required high level negotiation skills, which Nash, Sacre, Lock, and Ross (2011) describe as integral to effective communication, which was also outlined in the previous section on communication. The combination of being able to read the situation and then follow through with appropriate negotiation skills is an important finding, and not often recognised in either job descriptions or the nursing research agenda. However, situational awareness is currently gaining momentum in the research agenda, particularly in relation to maintaining high quality safe care (Fore & Sculli, 2013; Stubbings et al., 2012).

Other aspects of the role highlighted by participants included the need for motivation and having a passion for teaching. They considered that they must be confident to inspire motivation, stimulate and influence appropriate learning for the students and consider each student individually.

**Barriers and enablers to providing best practice**

As discussed above, close engagement, clinical knowledge and effective communication could be seen as enabling best practice. There were also barriers to best practice in clinical facilitation. These barriers included professional isolation, lack of clear policies and guidelines, balancing professional loyalties, lack of educational foundations and performance feedback.

While clinical facilitators interacted daily with students, clinicians in the ward area and, to a limited extent, the university academic staff, all of these interactions did little to resolve a sense of alienation or marginalisation to
others. The clinical facilitators explained that they felt as though they were in 'no man's land', where they didn’t belong in the clinical arena because the university employed them. While employed by the university they did not feel as if they were part of the academic team culture. This perspective was also expressed by participants in Ferguson’s (1996) study some 20 years prior, who noted that “wanting to belong” (p 838) was an important issue for clinical facilitators new to the role.

Professional isolation is easy to understand when referring to registered nurses working in remote settings where they are often working independently (Bushy & Lieipert, 2005; Curran, Fleet, & Kirby, 2006). However, it is not well understood among nurses in formal hospital settings. Given the extent to which facilitators interact with undergraduate nursing students and other health care professionals every day in many different settings, it is surprising that there has been little published research on the subject. The clinical facilitators in this study felt that some academic staff were unaware of their feelings of isolation. Others felt that the feeling of isolation had improved over time from when they had first commenced clinical facilitation some ten years prior. This feeling of acceptance was attributed to academic staff recognising their experience as well as their own contribution to the clinical skill development and socialisation of the students in the ward areas. However, their role remains outside the traditional notion of academic staff, and their main link to the university is the professional practice office; through their interactions with the professional practice coordinators (clinical coordinators). Their ongoing concern with feeling isolated suggests that their relationships with other academic staff should be strengthened through networking, inclusion in staff meetings, planning and curriculum development. Addressing these barriers would help promote better teamwork, which is desirable in all aspects of nursing practice.

Besides their links to the professional practice coordinators, facilitators also need networks connecting them with other clinical facilitators, and to feel included in discussions and negotiations to ensure that their students are receiving the best possible placement experience. The clinical facilitators indicated that they had been required over time to become highly skilled
negotiators to provide the balance between university expectations and those of the clinical area to marry these two areas together. They identified that the lack of guidance in the role and limited policy information created uncertainty about their role. While they had received no formal preparation for negotiation with the health care providers the skill was transferrable from their nursing practice and was up to their own resourcefulness to develop these skills, which they refined over time. For negotiations to be successful they would have preferred clear guidelines from the university as to expectations while on clinical placement. Likewise, guidelines from the health care agencies would also have been helpful to them. The clinical facilitators were also concerned about their accountability to the course convenor for final decisions when a student was not meeting the expected standards. For example, they were unable to fail a student independently, which means that they were required to communicate back and forth with the course convenor to justify their actions in relation to the student. In terms of specific information, some facilitators wondered how they were expected to access the required policies of the clinical area and to whom they should report incidents and problems. It was not until discussing the loneliness associated with their professional isolation in the focus groups that these issues were identified as some of the barriers they faced on a day-to-day basis.

The transformation of employment conditions in contemporary academic settings also plays a role in disconnecting some staff from their employing organisation. Transformation focuses on the changing conditions and strategic innovations of the organisation (Arrowsmith & Pulignano, 2013). The clinical facilitators identified that casual employment was at times a barrier to providing stability in ones work life, particularly in not knowing when or whether they would be offered work from semester to semester. The casualisation of the clinical facilitation workforce means that facilitators may feel they are neither health care workers nor academic staff, exacerbating that feeling of loneliness and disconnection. Casualisation also means that they can have their job rescinded at any time. For many clinical facilitators there is no job stability and some constantly worry if there will be further employment from week to week. Another issue related to casualisation of the
workforce that has been identified in previous research is that casualisation can result in a risk of inappropriate skill mix to cover specialist nursing areas as well as a lack of clinical facilitators with experienced clinical skills (Wilson, Whitaker, & Whitford, 2012). These conditions could provide a poor experience for the students undertaking the clinical placement. Casually employed clinical facilitators without job security or a permanent position have long been considered soft targets for staff reductions (Aiken et al., 2014), particularly in the clinical practice area when an organisation is looking for savings. Financial constraints can therefore be a major impediment to best practice, given that staffing issues have not improved since the mid to late 90’s (Aiken et al., 2014; Lee et al., 2002). While the clinical facilitators did not specify casualisation as a barrier to clinical facilitation, the reality of their employment is that they work on an ‘as needs’ basis, and do not have the job security experienced by academic staff. This uncertainty could be seen as a barrier to the provision of best practice.

For experienced nurses re-entering a clinical environment as a clinical facilitator can also be daunting. Williams (2014) identified that teachers like nurses were required to manage their identity between being a teacher and that of a teacher educator. This management of identity is similar to that of the clinical facilitator who is required to be a clinical nurse first and transfer to the role of a nurse educator in the role of a clinical facilitator. The clinical facilitators explained that they found balancing their old role as a registered nurse on a ward with the new facilitation role quite difficult when they first commenced as clinical facilitators. The confusing situation caused by having to balance professional loyalty had the facilitator torn between which organisations held her allegiance. One participant in particular highlighted that having first facilitated in her home ward was detrimental in that she was torn between working as a registered nurse on the ward and learning how to be a clinical facilitator in the same setting. In addition, feedback from students about her performance as a clinical facilitator had been quite negative. On reflection she realised that there had been a conflict in facilitating in her place of fulltime employment and that while she knew the ward area intimately she felt compelled towards helping the ward staff rather
than working with students. Since that experience she has not facilitated in a ward in which she was previously a permanent staff member. In response to a similar situation another facilitator identified an alternative perspective, believing that working in the same hospital was beneficial because she knew the processes of the organisation.

The conflict that this level of familiarity creates could be detrimental to the students’ learning outcomes when the clinical facilitators are trying to please the ward staff and not engaging with the students who they are employed to look after. The clinical facilitators appeared to have similar experiences and challenges to those of university based teacher educators working in school based teacher education programs. Martin, Snow, and Franklin Torrez (2011) identified that teachers were required to negotiate a web of relationships which the clinical facilitators were also required to negotiate in their environment as facilitators of undergraduate student nurses in the clinical area. Williams (2014) acknowledges that teacher practice areas are complex, this is certainly the case within nursing practice settings where student nurses are exposed to varied clinical practice areas which require skilled clinical facilitators to provide support for the students.

Facilitators felt they often did not have the requisite education or curriculum knowledge to accommodate this educational role. The limited formal education that clinical facilitators had about the curriculum and their uncertainty about what the role of clinical facilitation entailed when they commenced their role, in some cases, some 15-20 years prior to the study, was relevant to their role. Some stated that they were unsure what they were getting into when they applied for the position of clinical facilitation. This lack of preparation seems to have been a long-standing problem as documented by Napthine in 1996. Lack of preparation has also been attributed to university budget constraints, as highlighted by Lee et al. (2002) and Napthine (1996). However, recruitment, preparation and retention of facilitators should be a major priority for schools of nursing and midwifery given their importance to student learning (Napthine, 1996). A final barrier to best practice identified by participants was the lack of research evidence to guide practice. While Courtney-Pratt et al. (2012) suggest that the clinical
facilitator role is extremely important, it is concerning that research to date has focused only on the terminology of the role, the student expectations of the role and the employers’ perspective of the clinical facilitator. Obviously the lack of research to guide practice hinders the opportunity for clinical facilitators to understand or aspire to best practice in clinical facilitation.

Enablers of best practice clinical facilitation included the provision of workshops, prior experience as a clinician, the experience of other clinical facilitators and their informal support and positive feedback from students and colleagues. The workshops provided by the university were usually held annually, providing the opportunity to network and obtain experience from other clinical facilitators through discussion about their experiences and how they have dealt with various aspects of the role. Prior experience was another major enabler. The skills developed through trial and error (Newman, 2007) in the role of clinical facilitation and guidance from more experienced clinical facilitators assisted the clinical facilitator to learn the role. Another enabler was the informal support that the experienced clinical facilitators provided for each other, when they met in the tearooms of health care agencies. They valued collegiality, highlighting the fact that these experienced clinical facilitators are professional and care for their colleagues in supporting and mentoring.

Positive comments received by clinical facilitators from students and, in some instances, other clinical facilitators and health care staff, provided valuable feedback and insight for the clinical facilitator to understand if they are making a difference to the students’ learning. The provision of feedback enables reinforcement that the clinical facilitator is doing a good job, which, in turn, is likely to develop confidence in the clinical facilitator about her/his abilities. Confidence can subsequently be beneficial to developing and enhancing the facilitators’ identity with the role.
Preparing for a best practice future: Lessons from the field

As was reported in Chapter 4 there were factors that attracted clinical facilitators to the role. Some of these included having a passion for education and being ‘tapped on the shoulder’ by another clinical facilitator as someone who seemed to be suited to the role. Interestingly, some of the facilitators had not considered the role until a colleague invited them to consider the facilitation role. This type of reputational recruitment may have potential as a strategy to use clinicians’ understanding of the role to identify appropriate colleagues. Other clinical facilitators were attracted to the idea of educating students, or gravitated to the role because they had become disenchanted with the clinical setting. One participant explained that her experience as a facilitator of graduates in the hospital setting had led her to believe that her skills and knowledge would be of benefit to student nurses, and she wanted to use her experience to support students.

All eleven clinical facilitators agreed that not all registered nurses would make good clinical facilitators, which was quite interesting as there is a requirement by the registering body of Australia that all registered nurses are expected to supervise other nurses (ANMAC, 2012). This supervision includes an element of teaching lower level nurses such as enrolled nurses and nursing assistants. While supervision and facilitation are different the two concepts are sometimes used interchangeably. All facilitators demonstrated an aptitude for clinical teaching, which was evident as they described their various teaching strategies with pride. They were adamant that those responsible for clinical teaching should also be adaptable across practice settings. This need for adaptability has been recognised in other professions, such as teacher education. Lawy and Tedder (2012), for example, explained that an important focus of teacher training reforms in the United Kingdom is to introduce qualifications designed to meet the professional needs of people in different situations and sectors. A similar reform in nursing education in both the UK and Australia would see a greater emphasis on clinical teaching, yet with shrinking education budgets the cost would be seen as prohibitive. As a result, there has been little attention to the preparation or professional development needs of clinical facilitators.
The clinical facilitators in this study had greater than 5 years’ experience in the role of clinical facilitation and some acknowledged that they had undertaken formal education. All seemed to have in-depth knowledge of teaching and learning processes due to their experience as registered nurses and clinical facilitators. Without the clinical facilitators having formal education it is likely that students would have a sub-optimal experience. While teaching and learning processes can be taught, the clinical facilitators identified that, outside of their briefing prior to the placements, they had not had any formal education on how to teach students. While their lack of educational preparation had not stopped these 11 clinical facilitators from taking on the role, a structured course provided when they first commenced facilitating may have provided better guidance than learning on the job through trial and error. This finding concurs with Scanlan’s (2001) findings, who identified that novice clinical teachers in Canada also learnt through this method of experiential learning. Her findings showed that little had changed from Ferguson’s (1996) study, which also found that facilitators learned as they progressed in the role. Some facilitators have found this experiential learning beneficial, but it was interesting that in the current study, some of the clinical facilitators craved formal education, albeit without a clear notion of what they really wanted from the education.

In the current study, learning on the job was seen as essential to their progressing through their journey as clinical facilitators. Those who, subsequent to taking on this role had completed some form of education in teaching, either the Certificate IV in Training and Assessment or Graduate Certificate in Higher Education reported that what they learned in gaining these qualifications reinforced their experiential learning. While some of the participants suggested that a university course for facilitation would be helpful for clinical facilitators, one participant who had over 15 years’ experience as a clinical facilitator expressed an alternative view. She was not convinced of the benefit of a formal course suggesting that her ongoing experience as a registered nurse then as a clinical facilitator had shaped her knowledge and best practice. Her reflections corroborate Eggertson’s (2013) commentary, which suggested that evidence-informed clinical knowledge can be gained
through personal motivation rather than only through master’s level preparation. However, having recently completed a Graduate Certificate in Higher Education the clinical facilitator mentioned above believed that theoretical knowledge confirmed her current practice. This insight suggests that there is a role for formal education to strengthen the pedagogical knowledge base of clinical facilitators. Perhaps formal education in combination with experiential learning would provide an optimal mix of knowledge for best facilitation practice. Some of the study participants explained that their experiences of facilitating across two to three universities and components of self-directed learning provided a greater understanding of the clinical facilitator role as well as learning and teaching strategies.

Reflection on practice as a basis for strengthening learning and teaching

Some of the facilitators developed strategies for teaching that had arisen from their reflection on practice. One of the generalist facilitators highlighted her experience with one of her students who could not read particularly well and did not understand what had been written in a client’s chart. When the facilitator discussed this in the focus group she indicated that she now asked all her students to read aloud to her at the commencement of a placement so that she could assess each student’s reading. The clinical facilitators change of practice in asking students to read aloud highlighted that she had reflected on the situation with her student who had dyslexia which developed a way to ensure that reading issues in future placements were addressed early on in a clinical placement. The clinical facilitator’s satisfaction with identifying student problems that were not related to the students’ knowledge and general skills generated an enthusiasm from the clinical facilitator to go beyond what was expected of her as a clinical facilitator. Another facilitator reflected on her experience of a student’s learning difficulties, highlighting that she went out of her way to address these with the university and the student’s parents to ensure that the student received equitable opportunities. These clinical facilitators displayed a
commitment to the students’ learning needs. Despite the comments of the two facilitators cited above some of the facilitators did not realise that they had changed their practice due to reflection on their practice. To use Donald Schon’s term, the clinical facilitators engaged in ‘reflection on action’ which would mean that the clinical facilitator has the ability to reflect back on something that has transpired (Yanow & Tsoukas, 2009). It would be interesting to explore the impact of introducing reflective practice courses for clinical facilitators that could be beneficial to their practice and normalise this strategy as supporting their teaching strategies. The clinical facilitators who participated in the current study openly discussed their experiences drawing on many varied situations that they had encountered with both students and staff. The strategy to have them reflect on their experiences was useful in having them identify their perceptions of the best practice of clinical facilitation.

Professional development for clinical facilitation

In the context of the focus groups, most of the clinical facilitators found articulating what they needed to advance their skills difficult, highlighting that some of the clinical facilitators who have been facilitating for many years may in fact, lack the educational language required for the role. While they stated that they wanted more education, they did not have a clear idea of what was available or what they wanted and appeared to be speaking predominantly about workshops. There appeared to be limited exposure to academic staff that could have provided educational guidance.

Academic staff expectations of the facilitator are that they will be educators providing educational support to the students who will ‘talk-the-talk’ as an educator while having the ability to work also as a clinician - the expectation is that they are able to do both equally as well. While there is the expectation that the clinical facilitators educate, clinical facilitators first start as registered nurses who are clinicians and then make the step across to education, which is a whole new role to that of caring for sick patients. This reminds us of the debate over whether good teachers are born or made,
which has been ongoing over years. The opinion of some of the clinical facilitators in the study was that there are registered nurses who make good teachers. Yet one of the generalist clinical facilitators also indicated that not every registered nurse can be a clinical facilitator, a comment that had been made previously by Napthine (1996). The participants in the current study acknowledged that some registered nurses are natural teachers; they explain nursing well and are passionate about student learning. Other registered nurses are not interested in developing teaching skills and do not have the temperament or the inclination to be educational role models to students (Penn, Wilson, & Rosseter, Sept. 30, 2008).

Currently limited education is provided to students on teaching theories or how to teach in Bachelor of Nursing curricula and there is no requirement that staff teaching in Bachelor of Nursing programs have formal teaching qualifications. Therefore, as student nurses have been exposed to clinical facilitators during clinical placements there is an assumption that once the student becomes a registered nurse they too will know what to do in practice. This assumption is an outdated view of education which was embodied in the ‘see one, do one, teach one’ philosophy of the 1960’s, 70’s and early 80’s (Mason & Strike, 2003). This approach was popular in the hospital education system where the student was shown a task then undertook it themselves and taught someone else. Mason and Strike (2003) contend that this method was not best practice or educationally sound without the educational foundation provided in the university lectures to support clinical practice. Although learning styles differ among individuals there are some components of the educational preparation for facilitation that need to be provided to ensure an adequate foundation for the role. These include: a foundational knowledge of education, educational terminology, educational theories, negotiation skills, conflict resolution between students and staff, and a better understanding of the role of both teachers and learners within health care organisations.

Given the ongoing need for well-prepared clinical facilitators, succession planning is another issue that requires the attention of both academic and clinical managers. The goal of succession planning is
organisational continuity to ensure strategic and operational effectiveness (Hampel, Proctor, & Deuter, 2010) which, when undertaken systematically can help in retention of staff. While succession planning is used in some areas of academia, particularly in leadership development (McMurray et al., 2012), to date there appears to be limited succession planning or structure to the ad hoc way in which clinical facilitators are recruited. Retaining well-prepared clinical facilitators who are interested in student learning and providing the best clinical placement for a student ensures that students gain an optimal placement. Hampel et al. (2010) explain that succession planning must go beyond the needs of the organisation to create job satisfaction for the individuals who are recruited. Structured planning of the requirements needed for all workers include career planning and development along with mentoring. In the case of clinical facilitation the needs of students require consideration to ensure that the clinical facilitator is being prepared adequately and understand the requirements of the role of a clinical facilitator. Duffield, Baldwin, Roche, and Wise (2013) have found that creating meaningful career development opportunities improved job satisfaction which, in turn, was found to be essential to both job satisfaction and retention.

Another facilitator explained that she felt it was her role to encourage people who she felt were really good with students to apply for positions as clinical facilitators. Other participants agreed that they had also encouraged registered nurses to apply for positions, therefore assisting in the recruitment process of clinical facilitators who they believed were student centred, reliable, honest and would provide a good experience to students when the student was buddied with them. Her view corroborates the perspective of Van Maele and Van Houtte (2012) who indicate that trust in another teacher leads to satisfaction in relationships, in the clinical facilitators case the ability to identify other registered nurses who are like minded, student centred and wanting to work with students in the clinical arena. Providing mentorship to the clinical facilitators and incorporating the clinical facilitators in on-campus staff meetings may assist with providing the clinical facilitators with guidance from staff who currently work within the academic arena. The following
sections will outline the strengths and limitations of the current study and provide recommendations for practice, education and future research addressing the issues discussed.

**Strengths and limitations of study**

Using the conceptual framework of reflective practice was helpful in that it provided the clinical facilitators with the opportunity to think about how they undertook the role of facilitation. Reflecting enabled them to recount what they remembered and felt about their first experiences as clinical facilitators. Some of the clinical facilitators found the reflection on their practice during the focus groups a little challenging, although using the concept maps appeared to assist them to order their thoughts. Recounting their experiences was good because the clinical facilitators provided this depth of information needed in order to understand their perspective of what has occurred in the role of clinical facilitation. They included what they believe is required for the role, and outlined the factors that have influenced the role during their experience as clinical facilitators. The facilitators were comfortable with the researcher and provided the researcher with an insight into the clinical facilitators' perspectives of best practice. In the participants' enthusiastic descriptions of exemplars of best clinical facilitation practice they described how they draw on their knowledge and the uniqueness of clinical teaching. Throughout their discussion they highlighted how different experiences had assisted them to change their practice with much of their reflection conducted after the event, therefore reflecting on the action.

This research has achieved its goal in providing insights into what constitutes best practice in clinical facilitation of undergraduate nursing students from the perspective of clinical facilitators. The study provided rich data that informed the development of a clinical facilitation model of best practice that lends itself to validation in future research studies. While the current study used a convenience sample involving a small group of facilitators from a single university in one Australian city who had greater than five years' clinical experience, many participants had prior experience with
other universities. Extending the study to include clinical facilitators from other universities and other states would provide further insight into clinical facilitator perspectives, as would the inclusion of clinical facilitators with less than five years’ experience as a clinical facilitator of their perspectives of best practice for the role of the clinical facilitator.

**Recommendations for practice**

The study identified several areas where the practice associated with clinical facilitation could be adjusted to improve the effectiveness of people in this role. These relate primarily to support systems, training, lines of communication and opportunities for feedback. The development of clinical facilitator networking groups and provision of names of experienced clinical facilitators who are prepared to be contacts may be beneficial in that it could decrease the professional isolation that many clinical facilitators currently experience. Another way to overcome the feeling of isolation is through support for clinical facilitators from the academic staff to ensure that they are not feeling that they are on the fringe of the academic and clinical arenas. The opportunity of the clinical facilitator to engage in on campus as well as clinical facilitation off campus would provide the opportunity for collaboration. These interactions would allow academic staff, as experienced nurse educators, the opportunity to support the clinical facilitators in their role in the clinical areas and provide guidance in educational foundations for facilitation.

The study highlighted the need for a recommendation that clinical facilitators are not assigned to facilitate in the ward in which they practise as registered nurses to eliminate any conflict of interest that may occur. The research findings identified that clinical facilitators require feedback on their performance as clinical facilitators in the role of educator and clinician in the ward areas. Therefore the development of performance appraisal tools separate to those undertaken by students should be undertaken by ward or educational staff of the health care agency to assist university staff to monitor clinical facilitator performance. While the clinical facilitator is predominantly a sessional staff member it is important to remember that all staff requires both
negative and positive feedback to improve performance. The recommendations are therefore as follows:

1) Formalise opportunities for clinical facilitator networks
2) Address the issues of professional isolation while working as a clinical facilitator by providing the opportunity for regular debriefing sessions with academic staff.
3) Provide regular feedback to clinical facilitators including formalised annual performance development sessions
4) Provide opportunities to attend staff meetings and networking opportunities with academic staff

Recommendations for education

Clinical facilitators play a key role in the overall education of nurses. The study identifies several key areas in which education is directly relevant to the work of the clinical practitioners themselves. A recommendation from the findings is that registered nurses interested in facilitating students undertake educational qualifications as part of their condition of employment. This may provide them with an understanding of learning theories and teaching skills to assist with their ability to provide the best possible experience for the students. Therefore for future facilitators to learn about clinical facilitation and balancing the role, experienced facilitators need to work with and guide novice facilitators with a guidebook to give clear direction on clinical facilitation and the expectations of universities, curriculum and health care agencies. Given the dearth of published material to guide facilitators it would be useful to develop relevant well-structured courses, which would be the key to providing meaningful education for clinical facilitators. This would provide knowledge that informs and develops clinical facilitation skills to enhance the clinical facilitators’ understanding of their role and educate novice clinical facilitators in the role of best practice. The development of guidelines around best practice in clinical facilitation will benefit firstly, the clinical facilitators’ knowledge, and secondly provide skilled staff who provide student centred clinical placement support.

1) Provide exposure to academic staff and professional development opportunities for experienced clinicians who are interested in
becoming clinical facilitators supported by professional organisations.

2) Provide opportunities for continuing education that would include exposure to laboratory and teaching strategies.

3) Provide support with mentorship for education of clinical facilitators.

4) Provide opportunity for academics to gain knowledge from the clinical facilitators to add value to curriculum development.

5) Provide education to enhance practice, including reflective practice.

**Recommendations for research**

The study addresses the significant gaps in knowledge, identified in the literature review by contributing to the Australian and international body of knowledge relating to clinical facilitation of undergraduate nursing students. The value of this study lays not only in the findings but also in the collaborative involvement of the clinical facilitators. Their involvement offers opportunities for increased understanding of the clinical facilitation role and the impact that clinical facilitators have in the learning environment with students. This study raises issues that warrant further investigation and research. The following research studies are recommended:

1) Inquiry into the perspectives of students about best practice by clinical facilitators. This may provide insights into what students consider best practice and what expectations they have of clinical facilitators.

2) Further exploration of the clinical facilitators’ skills and what is considered essential elements of everyday practice in clinical facilitation.

3) Exploration of the student outcomes from varying models of facilitation.

4) Exploration of the impact that clinical facilitators have on health care staff while they are supporting the learning needs of students.

The study has confirmed the contributions of clinical facilitators to the educational preparation of undergraduate student nurses, integrating theory with practice through the use of *best practice*.
Conclusion

In conclusion this study has identified a number of pertinent issues through the exploration and interpretation of eleven clinical facilitators’ perceptions of best practice in clinical facilitation of undergraduate nursing students and the clinical facilitators’ views on what influences best practice. The participants’ reflection on their experiences has led to my greater understanding of the clinical facilitators’ role, through identification of their personal and professional practices. These experienced clinical facilitators reported a perception that their experiential knowledge as both a registered nurse and a clinical facilitator has allowed them to develop best practice processes for clinical facilitation. While the clinical facilitators are given the opportunity to be autonomous they still crave contact with the academic staff at the university and are desperate to have feedback on their performance as facilitators and, in particular, their documentation of student progress. Findings from this study concur with studies of nursing student perceptions of a good clinical facilitator in that they want someone who has excellent knowledge, clinical competence and strong interpersonal skills to communicate with both clinical and academic colleagues and settings.

Discussions with the clinical facilitators in this study highlighted that they found the lack of research into their role frustrating, considering that it is often referred to as an important role. They seemed to think the lack of research indicated that the role was undervalued by both the educational and clinical partners. On completion of this study, an optional workshop will be offered to the participants of the study and other clinical facilitators to provide feedback on the findings.
REFERENCES


Cantwell, R., Archer, J., & Bourke, S. (2001). A comparision of academic experiences and achievement of university students entering by
traditional and non-traditional means. Assessment and Evaluation in Higher Education., 26(3), 221-234. doi: 10.1080/02602930120052387


Van Maele, D., & Van Houtte, M. (2012). The role of teacher and faculty trust in forming teachers’ job satisfaction: Do years of experience make a


Appendix A

Broad questions for focus groups:

1. When you are allocated your group of students what types of strategies do you use to facilitate the students learning?

2. What has helped shape your knowledge of clinical facilitation?

3. Can you explain what best practice in clinical facilitation might include? Do you believe that you engage in best practice?

4. Has anyone found any difference in facilitating different levels of students and what have these differences been? If there have been differences, how have you managed this? (For example, do you judge the students ability/performance differently, is there a difference in how you assess them clinically? Are there differences in liaising with the university?)

The following questions will be used although further questions may be generated from the data collected from the focus groups:

1. Tell me about your clinical facilitating. How has it changed from the first time you facilitated until now? In your opinion what factors have influenced those changes over time?
2. What attracted you to the role of the clinical facilitator?
3. Tell me about your experiences (both as a learner and teacher) facilitating the students and some of the influences.
4. Tell me how you learned about clinical facilitation?
5. What education have you received to undertake the role of clinical facilitation?
6. If you think back to when you first began clinical facilitation, can you describe to me some of the changes you have made in your facilitating?
7. What are the barriers you encounter in the role as clinical facilitator?
8. What are the strengths and constraining factors in the organizational structures and processes of clinical facilitation?
9. **In your opinion**: What constitutes best practice in clinical facilitation?
Appendix B

GRiffith University Human Research Ethics Committee
17-May-2013

Dear Mrs Needham

I write further to your application for ethical clearance for your project "NR: Best practice in clinical facilitation of undergraduate nursing students: An exploratory study of the perspectives of clinical facilitators." (GU Ref No: EDN/55/13/HREC). This project has been considered by Human expedited review 1.

The Chair resolved to grant this project provisional ethical clearance, subject to your response to the following matters:

Your response to question E1 does not provide sufficient information about: a) the research questions and/or established issue to be explored by the research; b) the methods that will be employed; c) a summary of the literature review that informed a and b; d) what participants will experience; and e) how this research design will allow the research questions/issues to be explored.

In relation to Section E2 of the application form, the National Statement on Ethical Conduct in Human Research requires that ethical review bodies receive information about each researcher’s expertise (e.g. qualifications, experiences, skills, relevant publications, prior grants, etc.) relevant to the ethical, appropriate and successful conduct of this research proposal. Please provide further brief information about the relevant expertise of each researcher.

Please note that, in the case of student research, a member of the student’s supervisory team must be listed as the contact person/Chief Investigator on all materials provided to participants and participating organisations. The research student cannot be the listed contact person. Please also ensure that all materials identify the PhD Candidate (or Honours researcher) as “Student Researcher”, and ensure that all materials clearly state that they are conducting the research in their capacity as a Griffith University student.

Please correct the contact details of the Manager, Research Ethics to 373 54375 or research-ethics@griffith.edu.au.

Please amend the informed consent package to include a legal privacy statement. Please note that the Commonwealth Privacy Commissioner has classified opinions as personal information. Sample wording for such statements is contained in 7.10 in Booklet 22 of the Manual: The conduct of this research involves the collection, access and/or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or
other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will at all times be safeguarded. For further information consult the University’s Privacy Plan at http://www.griffith.edu.au/privacy-plan or telephone (07) 3735 4375.

Please note the instructions for focus group participants should ask them to respect the privacy of other participants.

If you intend to audio or video record the focus groups and/or interviews, please ensure this is outlined in the informed consent materials.

The contact officer signing sF1 of the hard copy of the Expedited Ethical Review Checklist. If you did not generate a hard copy when you first submitted your application we can email a PDF copy to you.

The primary supervisor signing sF1A of the hard copy of the Expedited Ethical Review Checklist. If you did not generate a hard copy when you first submitted your application we can email a PDF copy to you.

An appropriate authorising officer, who is not a member of the research team, completing and signing sF2 of the hard copy of the Expedited Ethical Review Checklist. If you did not generate a hard copy when you first submitted your application we can email a PDF copy to you.

This decision was made on 17-May-13. Your response to these matters will be considered by Office for Research.

The ethical clearance for this protocol runs from 17-May-13 to 31-Jan-15.

Please forward your response to Ms Kristie Westerlaken, Policy Officer, Office for Research as per the details below.

Please refer to the attached sheet for the standard conditions of ethical clearance at Griffith University, as well as responses to questions commonly posed by researchers.

It would be appreciated if you could give your urgent attention to the issues raised by the Committee so that we can finalise the ethical clearance for your protocol promptly.

Regards

Ms Kristie Westerlaken
Policy Officer
Office for Research
Bray Centre, Nathan Campus
Griffith University
ph: +61 (0)7 373 58043
fax: +61 (07) 373 57994
email: k.westerlaken@griffith.edu.au
web:
Researchers are reminded that the Griffith University Code for the Responsible Conduct of Research provides guidance to researchers in areas such as conflict of interest, authorship, storage of data, & the training of research students. You can find further information, resources and a link to the University's Code by visiting http://policies.griffith.edu.au/pdf/Code%20for%20the%20Responsible%20Conduct%20of%20Research.pdf

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Dear Mrs Needham

I write further to the additional information provided in relation to the conditional approval granted to your application for ethical clearance for your project "NR: Best practice in clinical facilitation of undergraduate nursing students: An exploratory study of the perspectives of clinical facilitators." (GU Ref No: EDN/55/13/HREC).

This is to confirm receipt of the remaining required information, assurances or amendments to this protocol.

Consequently, I reconfirm my earlier advice that you are authorised to immediately commence this research on this basis.

The standard conditions of approval attached to our previous correspondence about this protocol continue to apply.

Regards

Dr Kristie Westerlaken
Policy Officer
Office for Research
Bray Centre, Nathan Campus
Griffith University
ph: +61 (0)7 373 58043
fax: +61 (07) 373 57994
email: k.westerlaken@griffith.edu.au
web:

Cc:

Researchers are reminded that the Griffith University Code for the Responsible Conduct of Research provides guidance to researchers in areas such as conflict of interest, authorship, storage of data, & the training of research students. You can find further information, resources and a link to the University's Code by visiting http://policies.griffith.edu.au/pdf/Code%20for%20the%20Responsible%20Conduct%20of%20Research.pdf

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Appendix C

Participant Information and Consent Forms

Full Project Title:

Student Researcher: Judith Needham, Doctor of Education Candidate
Senior Investigator: Principal: Professor Anne McMurray
Associate: Professor Ramon Shaban

Dear ______________________

I am very interested in the role of clinical facilitators in helping our students achieve success in their Bachelor of Nursing program. I would like to invite you to take part in a research project that I am conducting as part of my Doctorate of Education at Griffith University. This Participant Information and Consent Forms explain the research study, outlining what is involved to help you decide if you want to participate. There are two consent forms to be completed: one for those participating in the focus group and one for participation in the individual interview. Please read this information carefully.

You will be given a copy of this Participant Information and Consent Forms.

1. What is the purpose of this research project?

The aim of this project is to identify what clinical facilitators believe is best practice in clinical facilitation. Currently, we understand that there is a wide variety of facilitator roles and there is little research on learning and teaching needs of clinical facilitators or other support needs. If you are currently employed as a clinical facilitator the study may not change anything about your role; however, the findings may help inform new directions or preparation for facilitators in future.

2. What does participation in this research project involve?

- Procedures

Once you have completed a consent form you will be asked to participate in a focus group. I will ask for some information on your educational and work history. Then, you will be asked to participate in a face to face interview on your experiences and expectations of the role. If you are able to participate in both it will be appreciated but if you can only volunteer for one or the other your input will still provide invaluable information.

- Reimbursement

There will be no cost to participate; and relevant information will be provided free to you. You will not be paid for your participation in this research.

3. What are the possible benefits?

The findings of this study will provide valuable information to assist with recommendations for the development of support for registered nurses who are interested in becoming clinical facilitators to maintain the quality of teaching and learning of undergraduate student nurses. We do not anticipate direct personal benefits from this project.

4. What are the possible risks?

This research project will not alter your employment as a clinical facilitator. This project will not use deceit or other measures that may cause physical or psychological harm to you. By law, the
researcher is obliged to report particular events regulatory and government authorities, such as criminal activity. A good example of Mandatory reporting is: The Child Protection Act 1999 (Qld) at section 148 requires that a responsible person who becomes aware or reasonably suspects harm must report that to the Chief Executive of the Department of Child Safety.

5. Do I have to take part in this research project?

Participation in this research project is voluntary. There is no pressure on you to take part. If you decide to participate and later change your mind, you are free to withdraw from the project without penalty.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your relationship with the researchers or educational facility.

6. How will I be informed of the final results of this research project?

You will be asked to provide contact details to the researcher if you wish a summary of the results to be forwarded to you upon completion of the research.

7. What will happen to information about me?

Any information obtained in connection with this research project will be de-identified. Your identity will remain confidential and information will only be used for the purpose of this research project. In order to protect your identification your research information will be coded and not supplied to anyone outside the research team. It will only be disclosed with your permission, except as required by law. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission. Grouped data will be used rather than individual data. All information will be kept in a secure locked filing cabinet for a period of five years from the date of completion of this study, and will be destroyed by paper shredder machine at the end of the storage period.

8. Can I access research information kept about me?

In accordance with relevant Australian and/or Queensland privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. Please contact one of the researchers named at the end of this document if you would like to access your information.

9. Is this research project approved?

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Griffith University. This project will be conducted according to the National Statement on Ethical Conduct in Human Research (2007 updated February 2013) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

10. Further information or any problems

If you require further information or if you have any problems concerning this project you can contact the chief investigator or any of the team members listed below. The researchers responsible for this project are: Professor Anne McMurray (A.McMurray@griffith.edu.au), Professor Ramon Shaban (R.Shaban@griffith.edu.au), or Mrs Judith Needham, School Of Nursing and Midwifery, Griffith University, 3382 1158 or email: j.needham@griffith.edu.au

11. Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

For complaints:
If you have any complaints or concerns about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Manager, Research Ethics, Griffith University
Telephone: 373 55585 or email research-ethics@griffith.edu.au
Appendix D

An example of concept maps from focus group 2.